

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada Registration District No. 2
 City of Boise Primary Registration District No. 1004-
 (No. 410 State Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Peroni

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. S 44564
 Registered No. 31

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Single
 (Write the word.)

6. DATE OF BIRTH

Feb 4 1924
 (Month) (Day) (Year)

7. AGE

Still Born
 yrs. mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

none

9. BIRTHPLACE

(State or Country)

Boise, Idaho

10. NAME OF FATHER

Vincent Peroni

11. BIRTHPLACE OF FATHER

(State or Country)

Italy

12. MAIDEN NAME OF MOTHER

Matilda Simpson

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

V. Peroni

(Address)

Boise

15.

Filed

Feb 5 1924

R. M. Pratt
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 4 1924
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw h. alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still birth

[7 mos. fetus, born dead]

(Duration) yrs. mos. ds.

Contributory Separation of 2/3 of placenta from the fetus

(Duration) yrs. mos. ds.

(Signed) L. P. McCalla M. D.

2/5/24 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

St. John's Cemetery

DATE OF BURIAL

2/5/24

20. UNDERTAKER

Edmund Videnski

ADDRESS

Boise

Dr. McCalla

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

REASON REQUESTED FOR DENIAL
REWRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.		STATE OF IDAHO	
1. PLACE OF DEATH		DEPARTMENT OF PUBLIC WELFARE	
County of <u>Bonneville</u>		BUREAU OF VITAL STATISTICS	
City of <u>Idaho Falls</u>		State File No. <u>S 44688</u>	
If death occurs away from usual residence, give facts called for under special information.		Local Registrar's No. <u>2</u>	
2. FULL NAME <u>Infant</u> <u>Rossland</u>		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
PERSONAL AND STATISTICAL PARTICULARS			
3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Single</u>	
(Write the word)			
6. DATE OF BIRTH <u>Jan</u> <u>A</u> <u>1924</u>			
(Month) (Day) (Year)			
7. AGE <u>Three</u> <u>Years</u>		IF LESS than 1 day how many hrs. or min.?	
8. OCCUPATION <u>Still born</u>			
(a) Trade, profession or particular kind of work			
(b) General nature of industry, business or establishment in which employed (or employer)			
9. BIRTHPLACE (State or Country) <u>Idaho Falls Ida.</u>			
10. NAME OF FATHER <u>Elmer J. Rossland</u>			
11. BIRTHPLACE OF FATHER (State or Country) <u>Lewis Co. Iowa</u>			
12. MAIDEN NAME OF MOTHER <u>Margaret C. Combs</u>			
13. BIRTHPLACE OF MOTHER (State or Country) <u>Shoshone Co. Idaho</u>			
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			
(Informant) <u>Elmer J. Rossland</u>			
(Address) <u>Idaho Falls, Ida.</u>			
15. <u>Jan</u> <u>9</u> <u>1924</u>			
Local Registrar <u>Wm. J. ...</u>			
MEDICAL CERTIFICATE OF DEATH			
16. DATE OF DEATH <u>1</u> <u>8</u> <u>1924</u>			
(Month) (Day) (Year)			
17. I HEREBY CERTIFY, That I attended deceased from <u>19</u> to <u>19</u> , that I last saw him alive on <u>19</u> , and that death occurred on the date stated above, at <u>M.</u>			
The CAUSE OF DEATH* was as follows:			
<u>Pneumonia</u>			
<u>Still born</u>			
(Duration) yrs. mos. ds.			
Contributory (Secondary) <u>Still born</u>			
(Duration) yrs. mos. ds.			
(Signed) <u>J. C. Ballister</u> M. D.			
19 (Address) <u>Idaho Falls, Ida.</u>			
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.			
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)			
At place In the			
of death yrs. mos. days. State yrs. mos. ds.			
Where was disease contracted if not at place of death?			
Former or usual residence			
19. PLACE OF BURIAL OR REMOVAL <u>Idaho Falls Ida</u>			
DATE OF BURIAL <u>11</u> <u>9</u> <u>1924</u>			
20. UNDERTAKER <u>Wm. J. ...</u>			
ADDRESS			

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

13

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Fremont

City of St. Anthony

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME (Stillbirth)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

February 21st, 1924

(Month) (Day) (Year)

7. AGE

Yrs. — Mos. — da. —

IF LESS than 1 day

how many — hrs.

or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or occupation in which engaged (or employer)

9. BIRTHPLACE

(State or Country)

St. Anthony, Idaho.

10. NAME OF FATHER

Edward Tout

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Julia Weaver

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ed Tout

(Address)

St. Anthony, Idaho.

15.

Filed Feb. 22nd, 19 24

W. M. Hansen
Local Registrar

CERTIFICATE OF DEATH

Registration District No. 99

Primary Registration District No. 2177

St.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 44759
Registered No. 37

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 21st, 1924

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him — alive on 19

and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Premature

Stillbirth

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) None M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Parker, Idaho.

DATE OF BURIAL

2/22nd 19 24

20. UNDERTAKER

None.

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 20 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

N 13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Fremont

City of St. Anthony

Registration District No. 99

Primary Registration District No. 2177

(No. _____ St.)

File No. 41761

Registered No. 535

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Received None (Stillbirth)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

February 9th, 1924

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Wilford, Idaho.

10. NAME OF
FATHER

Joseph Gould

11. BIRTHPLACE
OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME
OF MOTHER

Ella Andrews

13. BIRTHPLACE
OF MOTHER

(State or Country)

Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph L. Gould

(Address)

St. Anthony Ida. R.F.D. #1

15.

Filed Feb. 11th, 1924

W. W. Hansen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb.

(Month)

9

(Day)

1924

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 _____ to 19 _____

that I last saw her alive on Feb. 9, 19 _____

and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

Unknown

(Duration) yrs. mos. ds.

(Signed)

Frank Drakins

M. D.

March 3, 1924

(Address) St. Anthony, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Wilford, Idaho.

DATE OF BURIAL

2/11 1924

20. UNDERTAKER

None

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

1613

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Lincoln*

City of *Lincoln*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bennie Osborn

CERTIFICATE OF DEATH

Registration District No. *37*

Primary Registration District No. *1085*

Lincoln Ida (St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *S 44885*

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

Feb 15 1924
(Month) (Day) (Year)

7. AGE

2 Yrs. *0* Mos. *0* ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Curtis Osborn

11. BIRTHPLACE OF FATHER

(State or Country)

Ill

12. MAIDEN NAME OF MOTHER

Ina McKinty

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Bennie Osborn

15.

Filed

Feb. 1 1924

John H. Hargrave
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 15 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, that ~~the deceased~~ *deceased* from

19 to *19*

that I last saw *her* alive on *19*

that death occurred on the date stated above, at *11 AM*

The CAUSE OF DEATH* was as follows:

Still born Dead a week or two. Cause unknown

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. D. Weaver M. D.

19

(Address) *Twin Falls*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Twin Falls

DATE OF BURIAL

2-16-1924

20. UNDERTAKER

E. D. Weaver

ADDRESS

Twin Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

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RECEIVED CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **S 44921**
 Registered No. **14**

1. PLACE OF DEATH

County of **Idaho**City of **Boise**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Stuart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6. DATE OF BIRTH

Mar. 26 - 1924

7. AGE

Still Born

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Barber, Idaho

10. NAME OF FATHER

O.T. Stuart

11. BIRTHPLACE OF FATHER

(State or Country)

Ga.

12. MAIDEN NAME OF MOTHER

Emma Roberts

13. BIRTHPLACE OF MOTHER

(State or Country)

Ga.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W McBratney

(Address)

Boise Idaho

15. Filed

Mar 26 1924**R. R. O'Neil**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar - 26 - 1924

(Month)

(Day)

19

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 26 1924 to Mar 26 1924that I last saw her on **Mar 26 1924**and that death occurred on the date stated above, at **2:20** M.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) Yrs. mos. ds.
 Contributory (Secondary) **Premature**

(Duration) yrs. mos. ds.
 (Signed) **O. H. Parker** M. D.

3/26 1924 (Address) **Boise, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Monist Hill Cemetery

DATE OF BURIAL

Mar 26 1924

20. UNDERTAKER

W McBratney

ADDRESS

Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of *Bannock* Registration District No. *28*City of *Boise* Primary Registration District No. *2461*

If death occurs away from usual residence, give facts called for under special information.

(No.)

St.

State File No. *S 45221*
Registrar's No. *4274*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Infant Bair

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

(Write the word)

6. DATE OF BIRTH

Mar 7 1924
(Month) (Day) (Year)

7. AGE

*Still Born*IF LESS than 1 day how many
hrs. or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Leo M. Bair

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Dolly Irene Barnes

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leo M. Bair
(Address) *156 N. 14th*

15.

Filed

*3/7**1924**J. H. Harris*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 7 1924
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *3-7-24* to *3-7-24* 19*24*that I last saw him alive on *Stillborn* 19*24*, and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Stillbirth.

(Duration) yrs. mos. ds.

Contributory (Secondary)

Had labor, breech presentation.

(Duration) yrs. mos. ds.

(Signed)

*W. H. Brothman M. D.**3-7-1924* (Address) *Franklin Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mountain View

DATE OF BURIAL

Mar 7 1924

20. UNDERTAKER

Chumack & Co.

ADDRESS

Boise

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

115

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V, S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Canyon
City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Durbin

CERTIFICATE OF DEATH

RECEIVED
APR 22 1924
JEROME

Registration District No. 3
Primary Registration District No. 10052
St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. S 45322
Local Registrar's No. 23

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDsingle
(Write the word)

6. DATE OF BIRTH

March 27- 1924
(Month) (Day) (Year)

7. AGE

IF LESS than 1
day how many
hrs. or
min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FatherJ. A. Durbin11. BIRTHPLACE
OF FATHER

(State or Country)

Missouri12. MAIDEN NAME
OF MOTHERElma Gardner13. BIRTHPLACE
OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. A. Durbin

(Address)

Caldwell, Idaho

15.

Filed 3-28- 1924 John H. Incey
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 27 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
3/27 24 1924 to 3/27 1924

that I last saw h..... alive on..... 19.....
and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH was as follows

Stillborn Premature

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

3/28 1924 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... ds.
Where was disease contracted if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

Mar 28 1924

20. UNDERTAKER

W. Leckham

ADDRESS

Caldwell, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

NB

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Kootenai
 City of Coeur d'Alene

Registration District No. 30
 Primary Registration District No. 1057
 (No. 306, Forest Drive St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. S. 45718

Registered No. 1342

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Barbara Jean Scheibner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
 (Write the word.)

6. DATE OF BIRTH

April 11 1924
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day
 how many 0 hrs.
 or 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Edward Scheibner

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Violet Newman

13. BIRTHPLACE OF MOTHER

(State or Country) Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward Scheibner

(Address) Coeur d'Alene Idaho

15.

Filed 5/5/24 1924 D. D. Drennan
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr. 11 1924
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1924 to 1924

that I last saw him at home 1924

and that death occurred on the date stated above, at 9:30 M.

The CAUSE OF DEATH* was as follows:

Calamitous Mother

(Duration) Yrs. mos. ds.

Contributory Convulsions
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. H. Sturges M. D.

4/12/24 (Address) Coeur d'Alene Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cem. Coeur d'Alene

DATE OF BURIAL

4-13 1924

20. UNDERTAKER

Clarsedy

ADDRESS

Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No.

Primary Registration District No.

(No. St. Anthony (St.) Vernal)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Mr. & NallyState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. S 45891Registered No. 4360

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OF RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

June 9 '1924
(Month) (Day) (Year)

7. AGE

Premature Birth
Yrs. Mos. ds. IF LESS than 1 day
now many hrs.
or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Frank M. Nally

11. BIRTHPLACE OF FATHER

(State or Country) Ireland

12. MAIDEN NAME OF MOTHER

Gene M. Vek

13. BIRTHPLACE OF MOTHER

(State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank M. Nally(Address) Pocatello Id.

15.

Filed 6/10 1924
Local Registrar James Mountain Vek

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 9 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 9 1924 to June 9 1924
that I last saw him dead 6-9 1924
and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH was as follows:

Still birth at three and one half months. Cause unknown

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Arn. Newton M. D.June 19 24 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View June 10 1924

D. UNDERTAKER

ADDRESS

Schumacher Way Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bannock
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant

CERTIFICATE OF DEATH

Registration District No. 441

Primary Registration District No. 441

BUREAU

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 45919

Local Registrar's No. 4349

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female white

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6. DATE OF BIRTH

May 26 1924
(Month) (Day) (Year)

7. AGE

— Yrs. — Mos. — ds.

IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

none

9. BIRTHPLACE

(State or Country)

Pocatello, Idaho

10. NAME OF FATHER

Frank Clark

11. BIRTHPLACE OF FATHER

(State or Country)

Texas

12. MAIDEN NAME OF MOTHER

Ruth H. Allen

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Clark

(Address) 745 M. Harrison

15.

Filed May 27 1924

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 26 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26 1924 to May 26 1924

that I last saw her alive on May 26 1924, and that death occurred on the date stated above, at 5:30 PM.

The CAUSE OF DEATH* was as follows:

Illness

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

1924 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

Pocatello, Ida

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

mt View Cem.

May 27 1924

20. UNDERTAKER

ADDRESS

McNown Undert. Co. Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of LampsonCity of Nampa

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

JUL 7 1924

CERTIFICATE OF DEATH

Registration District No. 7Statistical District No. 1086

(No.)

(St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 46045

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

May 2 1924
(Month) (Day) (Year)

7. AGE

✓ Yrs. ✓ Mos. ✓ ds.IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Joseph J. Javorski

11. BIRTHPLACE OF FATHER

(State or Country)

Poland

12. MAIDEN NAME OF MOTHER

Stella Hoffman

13. BIRTHPLACE OF MOTHER

(State or Country)

Poland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

June 6 1924 Pearle J. Judds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5
(Month)2
(Day)1924
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

5/2 1924, to 5/2 1924that I last saw Still born 1924

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Still born, 7 mos. - Pre-E clampsie toxemia -
(Duration)..... Yrs. mos. ds.Contributory
(Secondary)

Duration..... yrs. mos. ds.

(Signature) Leo W. Chilton M. D.6/2 1924 (Address) Nampa, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Catholic Cem5-3 1924

20. UNDERTAKER

ADDRESS

F. K. HoffmanNampa

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Cassia
City of BurleyRegistration District No. 117Primary Registration District No. 2196

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby WilsonState of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 846661Registered No. 714

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6. DATE OF BIRTH

June 1924
(Month) (Day) (Year)

7. AGE

Still Born
Mos. ds.IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Complicated Eclampsia of Mother
Period of Gestation 6 mos
(Duration) 0 Yrs. mos. ds.

9. BIRTHPLACE

(State or Country)

Burley Ida

10. NAME OF FATHER

Mahouri A Wilson

11. BIRTHPLACE OF FATHER

(State or Country)

Utah Iron Co.

12. MAIDEN NAME OF MOTHER

Effie Glover

13. BIRTHPLACE OF MOTHER

(State or Country)

West Jordan Ut.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Burley Ida

15.

Filed

6-61924Dr. J. C. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 6 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 6 1924
to June 6 1924that I last saw deceased on June 6 1924

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Complicated Eclampsia of Mother
Period of Gestation 6 mos
(Duration) 0 Yrs. mos. ds.Contributory
(Secondary)(Duration) 0 Yrs. mos. ds.(Signed) J. C. Patterson M. D...... 19..... (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley Ida

DATE OF BURIAL

6-7 1924

20. UNDERTAKER

B. E. Johnson

ADDRESS

Burley

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms. *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of FreemontCity of St. Anthony

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99Primary Registration District No. 2177

(No. _____, St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. S 19111Registered No. 19111

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stillborn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female White

(Write the word.)

6. DATE OF BIRTH

May 12th, 1924
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) St. Anthony, Idaho.

10. NAME OF FATHER

Fred H. Mason

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Yerda Mason Abrahamson

13. BIRTHPLACE OF MOTHER

(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred H. Mason(Address) St. Anthony, Idaho.

15.

Filed May 15th, 1924 Wm. W. W. W.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 12 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Premature Birth.
Due to labor pneumonia in mother

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Frank D. Atkins M. D.(Address) St. Anthony, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Parker, Idaho.

DATE OF BURIAL

May 12 1924

20. UNDERTAKER

None

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

RECEIVED - CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

STANDARD

St.)

Registered No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY That I attended deceased from
May 23 1924 to May 23 1924

that I last saw him alive on 1924

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

5/24/24

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* **Never report mere** symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V, S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Ada
City of BoiseRegistration District No. 2Primary Registration District No. 1004(No. St. Luke's Hospital)State File No. S 46372Local Registrar's No. 179

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Temper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH

July 8 1924
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
.....hrs. or
.....Yrs.Mos.ds.min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF

Father

Geo. Raymond Temper

11. BIRTHPLACE

OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME

OF MOTHER

Cecil Hunter

13. BIRTHPLACE

OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. A. Temper

(Address)

1619 2nd 6th.

15.

Filed

July 9 1924 A. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 8 1924
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from July 8 1924 to July 8 1924, that I last saw him alive on July 8 1924, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still born, at 7th month
mother had eclampsia

(Duration)yrs.mos.ds.

Contributory
(Secondary)

(Duration)yrs.mos.ds.

(Signed)

P. P. French

M. D.

48 1924 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At placeyrs.mos.days. In the Stateyrs.mos.ds.
Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Time Cemetery July 9 1924

20. UNDERTAKER

ADDRESS

Quamers & Krebs Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

NB

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **8 46432**
Registered No. **9**

1. PLACE OF DEATH

Registration District No. **7**
County of **Canyon**
Primary Registration District No. **100.6**
City of **Naupoh** (No. **Macy Hospital**) St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Burman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white (Write the word.)

6. DATE OF BIRTH

July 1 24
(Month) (Day) (Year)

7. AGE

24
IF LESS than 1 day
how many **2** hrs.
or **2** min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Idaho**

10. NAME OF FATHER

W. A. Burman

11. BIRTHPLACE OF FATHER

(State or Country) **Utah**

12. MAIDEN NAME OF MOTHER

Viola Geyer

13. BIRTHPLACE OF MOTHER

(State or Country) **Utah**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **W. A. Burman Jr.**
(Address) **Caldwell**

15. Filed **Aug 1** 19 **24** **Mae Kerby**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 1 24
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1 1924 to **July 1 1924**
that I last saw him alive on **July 1 1924**

and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:

Stroke

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **H. P. Bellamy, M. D.**

7/6/1924 (Address) **Naupoh, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

7-2-1924

20. UNDERTAKER

Frank Robinson

ADDRESS

Naupoh

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **46433**
Registered No. **1006**

1. PLACE OF DEATH

County of Canyon Registration District No. 1
City of Naupaka Primary Registration District No. 1006
City of Naupaka ST. (No. Murray Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Burman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M W (Write the word.)

6. DATE OF BIRTH

July 1 1924
(Month) (Day) (Year)

7. AGE

— — — Yrs. Mos. ds. IF LESS than 1 day
how many 8 hrs. or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ✓
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

W. A. Burman

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Viola Zeyer

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. A. Burman
(Address) Baldwell #1

Filed Aug 1 19 24 Mac Kirby
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 1 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1 19 24 to July 1 19 24
that I last saw him alive on July 1 19 24

and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) — Yrs. — mos. — ds.
Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) H. P. Balding, M. D.

7/30/24 (Address) Naupaka, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Kohlerlawn Ceme 7-3 19 24

20. UNDERTAKER ADDRESS

Frederic K. Robinson Naupaka, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

115

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **S 46481**
Registered No.

1. PLACE OF DEATH

County of Blatah

Registration District No.

City of Bovill

Primary Registration District No.

City of Bovill (No.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jennie Martinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

July
(Month)5 1924
(Day) (Year)

7. AGE

born dead.
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Gus Martinson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Evelyn McGee

13. BIRTHPLACE OF MOTHER

(State or Country)

Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. J. P. Weber

(Address)

Bovill

15.

Filed 5 19 24 J. P. Weber
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July
(Month)5
(Day)1924
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Still birth

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

John P. Weber

M. D.

19

(Address)

Bovill Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name or origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

CERTIFICATE OF DEATH

46511

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Shoshone*
City of *Wallace*

Registration District No. _____

Primary Registration District No. _____

(No. *Wallace Hospital* St.)File No. *46*

Registered No. _____

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

*Infant John Matthew Whalen*If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

7

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Feb 14 24
(Month) (Day) (Year)

7. AGE

*Still born*IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

*Idaho*10. NAME OF
FATHER*John Matthew Whalen*11. BIRTHPLACE
OF FATHER

(State or Country)

*Idaho*12. MAIDEN NAME
OF MOTHER*Caroline Couture*13. BIRTHPLACE
OF MOTHER

(State or Country)

Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John M. Whalen

(Address)

Dudley Ida

Filed

Feb 17 1924 F L Jumper

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 14 24
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 14 1924 to *19*that I last saw him alive on *19*

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Still born child

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *Max T. Jumper* M. D.(Address) *Wallace Idaho**State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days In the State _____ yrs. _____ mos. _____ days

Where was disease contracted
if not at place of death?Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Idaho Feb 17 1924

20. UNDERTAKER

ADDRESS

R. B. Harsbrett Wallace, Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

NB

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. 616 S. 16 St.)

State File No. S 46566
Local Registrar's No. 187

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Roberts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

Aug 12 1924
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
hrs. or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country) Boise Idaho

10. NAME OF Father

W W Roberts

11. BIRTHPLACE OF FATHER

(State or Country) Washington

12. MAIDEN NAME OF MOTHER

Caroline Rogers

13. BIRTHPLACE OF MOTHER

(State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W W Roberts

(Address) 616 S. 16 27.

15.

Filed Aug 13 1924 R H Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 12 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-12 1924 to 8-12 1924

that I last saw him alive on 8-12 1924, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. J. J. ... M. D.

(Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Aug 13 1924

20. UNDERTAKER

ADDRESS

Summers & Kels Boise Idaho

NOV 29 1976

MAR 11 1977

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.**, **Carcinoma, Carcoma, etc.**, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **S 46582**
Registered No. **210**

1. PLACE OF DEATH

County of **Ada** Registration District No. **2**
City of **Boise** Primary Registration District No. **194**
St. Alphonsus Hospital (St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

Baby Morris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH **Aug, 29-1924**
(Month) (Day) (Year)

7. AGE **Still Birth** IF LESS than 1 day
how many..... hrs.
Yrs..... Mos..... ds. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

None.

9. BIRTHPLACE

(State or Country)

Boise, Idaho,

10. NAME OF FATHER

Geo. R. Morris

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Emma E. Hixon

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. McBratney
(Address) **Boise Idaho**

15.

Filed **Sept. 2** 19 **24** **R. H. Pratt**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 29 - 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Aug 29 1924** to **Aug 29 1924** that I last saw him alive on **19** and that death occurred on the date stated above, at **6 P.M.** The CAUSE OF DEATH* was as follows:

still birth

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Alfred E. J. M. D.
Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

8/30 1924

20. UNDERTAKER

W. McBratney

ADDRESS

Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should
state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is
very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Commerille
City of Idaho Falls

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 73
Primary Registration District No. 2100
(No. 1225 1226 St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. S46683
Local Registrar's No. 77

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

July 21 at 1924
(Month) (Day) (Year)

7. AGE

Stillbirth

IF LESS than 1
day how many
hrs. or
min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FatherLee Walker11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho12. MAIDEN NAME
OF MOTHEREris Parke13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lee Walker

(Address)

1226 1/2 St. Idaho Falls, Idaho

15.

Filed July 23 19 24 W. J. Walker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Still born July 21
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still born
No apparent cause
(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

July 23 1924 W. J. Walker M. D.
(Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls, Idaho

DATE OF BURIAL

July 24 1924

20. UNDERTAKER

Walker

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bonneville Registration District No. 73
City of Ida Falls Primary Registration District No. 2140
(City) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby - Dick

State File No. S 46888
Local Registrar's No. 73

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Infant
(Write the word)

6. DATE OF BIRTH

July 8 1924
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds. IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Elliot Dick

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Eliz. Eddington

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Elliot Dick
Ida Falls

15.

Filed

July 9 1924 Wm. H. Hallister
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 8 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/8 1924 to 7/8 1924

that I last saw her alive on 7/8 1924
and that death occurred on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

7-8-1924 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ida Falls 7-8 1924

20. UNDERTAKER

ADDRESS

B. E. Woodward Ida Falls

Local Registrar

Hallister

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

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CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nez Perce
City of LewistonRegistration District No. 96
Primary Registration District No. 1009
(No.) _____ St.)File No. S 46849
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Still B Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDM

(Write the word.)

6. DATE OF BIRTH

August 8 1924
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Geo Brown

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Mabel Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

S. H.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Smith (per All)
(Address) _____

15.

Filed Sept-8 1924 Simon E Brown
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 18 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 18 1924 to Aug 18 1924
that I last saw h. Still B Brown 19
and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Still B Brown

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

John H. Allen D.19. (Address) Lewiston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston

DATE OF BURIAL

Aug 19 1924

20. UNDERTAKER

Vassar Co

ADDRESS

Lewiston

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **S 46922**
Registered No. **228**

1. PLACE OF DEATH

County of **Ada** Registration District No. **2**
City of **Boise** Primary Registration District No. **1904**
St. Lukes Hospital (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Laura Isabel Petrie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **W.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)

6. DATE OF BIRTH

Still Birth
(Month) (Day) (Year)

7. AGE

Still Birth
Yrs. Mos. ds.

NE LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

None.

9. BIRTHPLACE

(State or Country)

Boise, Ida.

10. NAME OF FATHER

David Petrie

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Beatrice Carter

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. M. Bratney

(Address)

Boise, Idaho.

15. FREE

Sept 29 24

R. A. Paul
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 25-1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

9/25-1924 to **9/25-1924**
that I last saw **her** **9/25-1924**
and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:

Still Born Hemorrhage
Hemorrhage in mother
from ruptured uterus.
(Duration) Yrs. mos. ds.

Contributory (Secondary)

Hemorrhage of mother

(Duration)

Yrs. mos. ds.

(Signed)

David A. Bratney D.

9/26 1924

(Address) **Boise, Idaho.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

None.

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

11/30 1924

20. UNDERTAKER

W. M. Bratney

ADDRESS

Boise
Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

115

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **S 46956**
Registered No. **4416**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of **Bannock** Registration District No. **28**
City of **Pocatello** Primary Registration District No. **2161**
(No. **Sign** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Not named

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male **White** **Infant**
(Write the word.)

6. DATE OF BIRTH.

8/26 **1924**
(Month) (Day) (Year)

7. AGE

Still Born
IF LESS than 1 day how many hrs. or min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Single
Infant

9. BIRTHPLACE

(State or Country)

Pocatello, Ida

10. NAME OF FATHER

Robert Clayton McKee

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Anna M. Luell

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Robert C. McKee

(Address)

Idaho

15.

Filed

8/26 **1924** **J. J. Young**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

8/26 **1924**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 26, 1924 to **Aug 26, 1924**
that I last saw him on **Aug 26, 1924**
and that death occurred on the date stated above, at **11:50** M.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

J. J. Young M. D.

1924 (Address)

Pocatello, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days In the State Yrs. mos. days

Where was disease contracted if not at place of death? **Still Born**

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pocatello, Ida **8/27, 1924**

20. UNDERTAKER

ADDRESS

Robert C. McKee **Idaho**

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-19.

Springer
CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **47170**
Registered No. **253**

1. PLACE OF DEATH

County of *Ada*City of *Boise*Registration District No. *2*Primary Registration District No. *1004*(No. *St. Lukes Hospital* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sophia P. Moon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

Oct 26 - 1924

(Month)

(Day)

(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many *0* hrs.
or *—* min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Bernie W. Moon

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Lacie A. Brown

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bernie W. Moon

(Address)

15.

Filed

*Oct. 27 1924**P. H. Pratt*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 26 1924

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *19* to *Oct 26 1924*that I last saw *her* alive on *6* *19*and that death occurred on the date stated above, at *10:30 A.M.*

The CAUSE OF DEATH* was as follows:

Still born(Duration) Yrs. mos. ds.
Contributory *Breach presentation*
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. S. Springer* M. D.*10/26 1924* (Address) *Boise Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Myrtle Hill Cem. *Oct 28 1924*

20. UNDERTAKER

Summers & Preb.

ADDRESS

Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada Registration District No. 2
 City of Bainbridge Primary Registration District No. 1004
 (No. 1004 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Daoust

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 47173

Registered No. 2477

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White Single
 (Write the word.)

6. DATE OF BIRTH

10 21 24
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Student

9. BIRTHPLACE

(State or Country)

Bainbridge

10. NAME OF FATHER

Bertille E. Daoust

11. BIRTHPLACE OF FATHER

(State or Country)

Ontario Canada

12. MAIDEN NAME OF MOTHER

Ruth Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bertille E. Daoust
 (Address) 412 E. 5th St

15.

Filed Oct 22 19 24 R. H. Pratt
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 20 19 24
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21 19 24, to Oct 21 19 24.

that I last saw him alive on 19.

and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Still born -

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. R. H. Pratt M. D.

19 24 (Address) Ordinary Baby Bainbridge

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Bainbridge

19. PLACE OF BURIAL OR REMOVAL

St. John's Cemetery

DATE OF BURIAL

10/22/1924

20. UNDERTAKER

Shirley Hidenfeld

ADDRESS

Bainbridge

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Cassia
City of Burley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby McDonald

RECEIVED
CERTIFICATE OF DEATH

Registration District No. 117
Primary Registration District No. 2196
STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. S 47320

Local Registrar's No. 732

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

Sept 5 1924
(Month) (Day) (Year)

7. AGE

Still Born.

IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Burley, Ida.

10. NAME OF FATHER

Francis Bertram McDonald

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Getta McBride

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. B. McBride
(Address) Burley, Ida.

15.

Filed 9-7 1924 by J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 5th 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19 ,
that I last saw him alive on 19 ,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn
Premature Detachment of
Placenta, 7th month gestation
(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.
(Signed) J. C. Patterson M. D.

1924 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley, Idaho

DATE OF BURIAL

9/7/1924

20. UNDERTAKER

L. B. Galloway

ADDRESS

Burley, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "**Laborer, "Foreman, "Manager, "Dealer, etc.,** without more precise specifications, as **Day-laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "**Epidemic cerebrospinal meningitis**"); **Diphtheria** (avoid use of "**Croup**"); **Typhoid fever** (never report "**Typhoid Pneumonia**") **Lobar pneumonia; Bronchopneumonia** ("**Pneumonia**," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "**Cancer**" is less definite; avoid use of "**Tumor**" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "**Asthenia, "Anaemia**" (merely symptomatic), "**Atrophy, "Collapse, "Coma, "Convulsions, "Debility, "Congenital, "Senile, etc., "Dropsy, "Exhaustion, "Heart Failure, "Hemorrhage, "Inanition, "Marasmus, "Old age, "Shock, "Uraemia, "Weakness, etc.,** when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, "PUERPERAL peritonitis, etc.** all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "**Contributory.**"

1. PLACE OF DEATH

RECEIVED

Registration District No.

County of Lemhi

OCT 15 1924

Primary Registration District No.

2116

File No.

City of Salmon (No. 1) St.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Still Born

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white

(Write the word.)

6. DATE OF BIRTH

Birth - 19th 1924
(Month) (Day) (Year)

7. AGE

Still Born.
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Salmon Idaho.

10. NAME OF FATHER

Clarence James Hoerning

11. BIRTHPLACE OF FATHER

(State or Country)

Stockton Mo.

12. MAIDEN NAME OF MOTHER

Nancy Jane Long.

13. BIRTHPLACE OF MOTHER

(State or Country)

Salmon Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bertha W. Rose.

(Address)

Salmon Ida.

15.

Filed 12-10

1924

M. W. Harris
Local Registrar

16. DATE OF DEATH

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw h. alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still born - likely due to toxemia of unbalanced diet.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. F. Hannel M. D.Aug 21 1924 (Address) Salmon

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salmon CemeteryAug 20 1924

20. UNDERTAKER

ADDRESS

Wm C. Baker Salmon Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every notation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificate.

Current Complete April 1924 STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

47453

1 PLACE OF DEATH Barnack State Idaho Registered No. 4
County _____
Township _____ or Village _____
City Pocatello No. St. Anthony Hospital St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Andrew Webster Cutler

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Ind. 1/8 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) April 12 - 1924

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At home

(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Pocatello
(State or country) Idaho

10 NAME OF FATHER Andrew F. Cutler Jr

11 BIRTHPLACE OF FATHER (city or town) Idaho
(State or country)

12 MAIDEN NAME OF MOTHER Lavinia Webber

13 BIRTHPLACE OF MOTHER (city or town) Humboldt
(State or country) Iowa

14 Informant Andrew F. Cutler
(Address) Post Hall, Idaho

15 Filed _____, 19 _____ REGISTRAR

11-3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1924
I HEREBY CERTIFY, That I attended deceased from

April 12, 1924, to April 12, 1924,

that I last saw him alive on April 12, 1924,

and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Stillborn with aid of forceps!
at term,

(duration) 0 yrs. 0 mos. 0 ds.
CONTRIBUTORY Large head reduced by instruments.
(SECONDARY)

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Yes Date of Apr 12 - 1924

Was there an autopsy? No

What test confirmed diagnosis? Digital touch

(Signed) Henry R. Wheeler, M. D.

, 19 (Address) Post Hall, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. * (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Mountain View Cemetery
Pocatello, Idaho Apr 13 1924

20 UNDERTAKER ADDRESS

Thornaker Hall Pocatello Idaho

ED STATES STANDARD CERTIFICATE OF DEATH

by U. S. Census and American Public Health Association

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Pneumopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.; *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anemia" (merely symptom-

atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Infantion," "Marasmus," "Old age," "Shock," "Tremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

11—3184

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
S 47459
File No.

1. PLACE OF DEATH

County of *nez Perce*
City of *Lewiston*

Registration District No. *96*
Primary Registration District No. *1009*
(No. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(Still birth) *Nelson*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *m* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WID-OWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH

Sep 12 (Month) (Day) (Year) *1924*

7. AGE

still born

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Lewiston Idaho.

10. NAME OF FATHER

George L. Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Minnesota.

12. MAIDEN NAME OF MOTHER

Esther Jacobson

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George L. Nelson

(Address)

Clarkston, Wash

15.

Filed *Oct-9* 1924 *Sam E. Bruce*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sep. 12 19 *24*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sep 12 19 *24* to *Sep 12* 19 *24*

that I last saw him _____ alive on _____ 19 _____

and that death occurred on the date stated above, at *6 A.M.*

The CAUSE OF DEATH* was as follows:

*Still birth, caused by
nephritis in mother.*

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Paul W. Johnson M.D.

9/12-19-24 (Address) *Lewiston Idaho.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

Clarkston wash

19. PLACE OF BURIAL OR REMOVAL

Clarkston wash

DATE OF BURIAL

9/12 19 *24*

20. UNDERTAKER

H. R. Merchant Clarkston wash

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-A-25M. 1-19.

1. PLACE OF DEATH

County of Boundary,

City of Bonners Ferry,

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elaine Say Morris,

RECEIVED
DEC 8 1924

CERTIFICATE OF DEATH

Registration District No.

Registration District No.

(No.)

(St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 47680

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White, Single (the word)

6. DATE OF BIRTH

October 29, 1924.
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many hrs. or min.?

Yrs. Stillborns.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Bonners Ferry,

10. NAME OF

Father John W. Morris,

11. BIRTHPLACE OF FATHER

(State or Country) Idaho,

12. MAIDEN NAME

OF MOTHER Frieda Smith

13. BIRTHPLACE OF MOTHER

(State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Morris

(Address) Bonners Ferry Ida.

15.

Filed Oct 29th 1924

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 29, 1924.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19.

that I last saw him alive on 19, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still birth

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. W. Gaellkner, M. D.

Oct 29, 1924 (Address) Bonners Ferry, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Bonners Ferry, Ida.

DATE OF BURIAL

Oct. 30, 1924

20. UNDERTAKER

A. M. Peterson.

ADDRESS

Bonners Ferry, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

1. PLACE OF DEATH

County of Shoshone
City of Wallace

Registration District No.

Primary Registration District No. 1011(No. Providence Hospital)File No. 73

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Ebell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word.)

6. DATE OF BIRTH

July 6th 1924
(Month) (Day) (Year)

7. AGE

Yrs. Mos. da.

IF LESS than 1 day
how many hrs.
or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wallace Idaho

10. NAME OF FATHER

Albert Ebell

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Irene Bean

13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Albert Ebell

(Address)

Wallace Idg

15.

Filed

July 8 1924FL Murphy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 6 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19.... to 19....

that I last saw him alive on 19....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

1924 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

none

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Idg July 8 1924

20. UNDERTAKER

ADDRESS

Ward and Co Wallace

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 37
 County of *Lincoln* Primary Registration District No. 1085
 City of *Lincoln* St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
 DEC 3 1924
 BUREAU OF VITAL STATISTICS

Shin Watanabe

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. *S 47873*
 Registered No. *1270*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Dec. 1 1924

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

FOR BINDING

UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Bannock*

City of *Greene*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED JAN 17 1925

CERTIFICATE OF DEATH

Registration District No.

Registration District No.

State File No.

Registrar's No.

Infant / Dalpino

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S 47956

4490

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male White Child
(Write the word)

6. DATE OF BIRTH

Dec 6 1924
(Month) (Day) (Year)

7. AGE Still Born
IF LESS than 1 day how many
hrs. or min.?
Yrs. Mos. ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE
(State or Country)

10. NAME OF Father Paul Dalpino

11. BIRTHPLACE OF FATHER Italy
(State or Country)

12. MAIDEN NAME OF MOTHER Leola Trahan

13. BIRTHPLACE OF MOTHER Montana
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Paul Dalpino

(Address) 660 N. 6th

15.

Filed 12/8 1924

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 6 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

home 19 24

that I last saw him alive on Still Born 19 24

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Still born eight month gestation. Premature birth - mother having choreic insanity - 4 premenstrual (Duration) Premature birth ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. F. Howard M. D.

1924 (Address) Potomac Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Mountain View

20. UNDERTAKER Schumacher Isaac

DATE OF BURIAL Dec 6 1924

ADDRESS Carey

Local Registrar

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bannock Registration District No. 28
City of Porath Primary Registration District No. 2161
If death occurs away from usual residence, give facts called for under special information.

State File No. S 47967
Local Registrar's No. 4101

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Infant Baby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant
(Write the word)

6. DATE OF BIRTH about Dec 14
Unknown 1 924
(Month) (Day) (Year)

7. AGE Stillborn IF LESS than 1 day how many hrs. or min.?
Yrs. Mos. ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work. Infant
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE (State or Country) Unknown (Porath)

10. NAME OF Father Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Coroner
(Address) Bannock County

15. Filed 12/20 1924 J. R. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH about Dec 14 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19 ,
that I last saw h. alive on 19 ,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Fallen in front of house 13 days
wrapped in newspaper
Stillborn.
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
17 (Signed) Arthur W. Hall Coroner
60 1924 (Address) Porath Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL Mountain View Cem DATE OF BURIAL Dec 20 1924

20. UNDERTAKER Schumacher & Hall ADDRESS Porath

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Bannock*

City of *Pocatello*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Organ

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White

Infant
(Write the word)

6. DATE OF BIRTH

December 20 1924
(Month) (Day) (Year)

7. AGE

Stillborn

IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Pocatello Idaho

10. NAME OF Father

Joseph Organ

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Della Fry

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*Mr M. E. Lure
Pocatello, Idaho*

15.

Filed

12/23 1924

J. Young
Local Registrar

CERTIFICATE OF DEATH

Registration District No.

28

Primary Registration District No.

2161

St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No.

S 47969

Local Registrar's No.

4513

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 20 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
12-20 1924 to *19*,

that I last saw h..... alive on..... 19.....
and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

*Premature Stillborn
caused by mother having
intestinal flu*

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

18 (Signed)

D. Gray

M. D.

1924 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Mountain View Cem

DATE OF BURIAL

Dec 23 1924

20. UNDERTAKER

Schumacher & Hall

ADDRESS

Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24 **RECEIVED** JAN 19 1925
CERTIFICATE OF DEATH
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **S 48235**
Registered No. **8**

1. PLACE OF DEATH. Registration District No. **70**
County of **Shoshone** Registration District No. **1011**
City of **Wallace** (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME **Still Born Girl - Geo. Kingsley**
If death occurred in a hospital, instead of street and number, give its NAME.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Fe M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Infant**
(Write the word.)

6. DATE OF BIRTH **Dec 6 1924**
(Month) (Day) (Year)

7. AGE **Still born** IF LESS than 1 day how many _____ hrs. or _____ min?
_____ yrs. _____ mos. _____ ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work. _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE **Wallace Ida**
(State or Country)

10. NAME OF FATHER **George Kingsley**

11. BIRTHPLACE OF FATHER **Minn.**
(State or Country)

12. MAIDEN NAME OF MOTHER **Gertrude Phillips**
Lorah Wallace

13. BIRTHPLACE OF MOTHER **Michigan**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **George Kingsley**
(Address) **Wallace Ida**

15. Filed **Dec 7 1924** **F L Jones**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **About Dec 1 to 3 1914**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Still Born** 1912, to _____ 191____
that I last saw h_____ alive on _____ 191____
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:
Uremia

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory _____
(Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) **H. W. Rath** M. D.
Dec 6 1924 (Address) **Wallace Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)
At place **Waller Hospital** In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL **Wallace Ida** DATE OF BURIAL **Dec 7 1924**

20. UNDERTAKER **W. H. Hays** ADDRESS **Wallace Ida**

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital)," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as *fracture of skull*, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Delayed Complete June 1924 STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
S 50868

Registered No. 11

RECEIVED
OCT 23 1923
BUREAU OF VITAL STATISTICS

Pt. Hall Reservation

State Idaho

or Village

No.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME

Thomas Bannock

(a) Residence. No.

St. Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Ind 4/4

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 10-1924

7 AGE

Years

Months

Days

IF LESS than 1 day, --- hrs. or --- min.

0

0

0

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Pt. Hall Reservation

10 NAME OF FATHER

Paul Bannock

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Boise Idaho

12 MAIDEN NAME OF MOTHER

Ida George

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Pt. Hall Reservation

14

Informant

Paul Bannock
Pt. Hall Idaho

15

Filed

, 19

REGISTRAR

11-2184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

June 10 1924

17 No doctor attending

I HEREBY CERTIFY, That I attended deceased from

, 19

, 19

that I last saw h----- alive on

, 19

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Stillborn at term

(duration)

yrs.

mos.

ds.

CONTRIBUTORY

(SECONDARY)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

None

(Signed)

Henry A. Wheeler

M. D.

, 19 (Address)

Pt. Hall Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Pt. Hall Reservation

June 11, 1924

20 UNDERTAKER

ADDRESS

Paul Bannock

Pt. Hall Idaho

MARGIN RESERVED FOR BINDING

8-200 d
V. S. No. 98

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The marital worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.; *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *so da.*; *Bronchopneumonia* (secondary), *10 da.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptom-

atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Note.—Individual offices may add to above list of unacceptable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gasstris, erysipelas, meningitis, metastases, necrosis, peritonitis, phlebitis, pyemia, septicemia, telanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

11-3134

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH 218-203 005 613
County of Benewah
City of St. Maries
No. 32 St. Bureau District No. 32 State File No. 118637
Hospital St. Maries Primary Registration District No. 2049 Local Registrar's No. 12
FULL NAME OF CHILD Ellen Ethel Kahellek

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Sex of Child Female Twin Triplet or other? None and Number in order of birth 1 Legitimate? Yes Date of birth Jan 3 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth <u>1</u>		Number of child of this mother now living, including present birth <u>1</u>	
FATHER		MOTHER	
FULL NAME <u>Karol Kahellek</u>	FULL MAIDEN NAME <u>Hazel Mae Wackup</u>		
RESIDENCE <u>Fernwood Ida</u>	RESIDENCE <u>Fernwood Ida</u>		
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>(Years)</u>	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>20</u> (Years)		
BIRTHPLACE <u>Montana</u>	BIRTHPLACE <u>Idaho</u>		
OCCUPATION <u>Mechanic</u>	OCCUPATION <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 5:35 A M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) O. A. Pokras
Physician

Address St. Maries Idaho

Filed 2-8 1924 O. H. Moyer

Registrar.

Registrar.

1

8

1

1

11

1. PLACE OF DEATH

County of *Bennett*
 City of *St. Maries*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Reg. District No. *32*
 Principal Registration District No. *2049*
 (No. of VITAL STATISTICS)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. *44359*
 Registered No. *2*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Jan 3 1924
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. *Jan 4 1924*
 Filed *St. Maries*
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 3 1924
 (Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from *1/3 1924* to *1/3 1924*
 that I last saw him alive on *1/3 1924*

and that death occurred on the date stated above, at *10* M.

The CAUSE OF DEATH* was as follows:

Still born
Face presentation with
knotted cord
 (Duration) yrs. mos. ds.

Contributory (Secondary)
9 months
 (Duration) yrs. mos. ds.

(Signed) *Carl Robins* M. D.
1/7 1924 (Address) *St. Maries, Ida.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woodlawn *1-5 1924*

20. UNDERTAKER

ADDRESS

Mitchell & Mueger St. Maries
Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

417-113009-393

County of BonnerCity of Priest River

No. _____ St. _____

Hospital Priest RiverFULL NAME OF CHILD Not named

RECEIVED

BUREAU OF CERTIFICATE OF BIRTH
STATISTICALRegistration District 21Primary Registration District No. 2121

(Certificate of no value without full name of child)

IDAHO
PUBLIC WELFARE
STATISTICS

118649

File No. 6Registered No. 321Sex of
Child

male

Twin
Triplet
or other?

{ and }

{ Number
in order
of birth }

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birthJan. 13, 1924
(Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1Number of children of this mother now living, including present birth 0FULL
NAME

FATHER

William Dagget

RESIDENCE

Priest River, Ida.

COLOR

White

AGE AT LAST
BIRTHDAY

24

(Years)

BIRTHPLACE

Neb.

OCCUPATION

Laborer

FULL
MAIDEN
NAME

MOTHER

Alice Lithgow

RESIDENCE

Priest River, Ida.

COLOR

White

AGE AT LAST
BIRTHDAY

19

(Years)

BIRTHPLACE

Idaho.

OCCUPATION

House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Dead
on the date above stated.at 2 P. M.
(Born ~~live~~ or stillborn)

* When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature) _____

Edward E. Gutzlaff M.D.
(Physician or midwife)

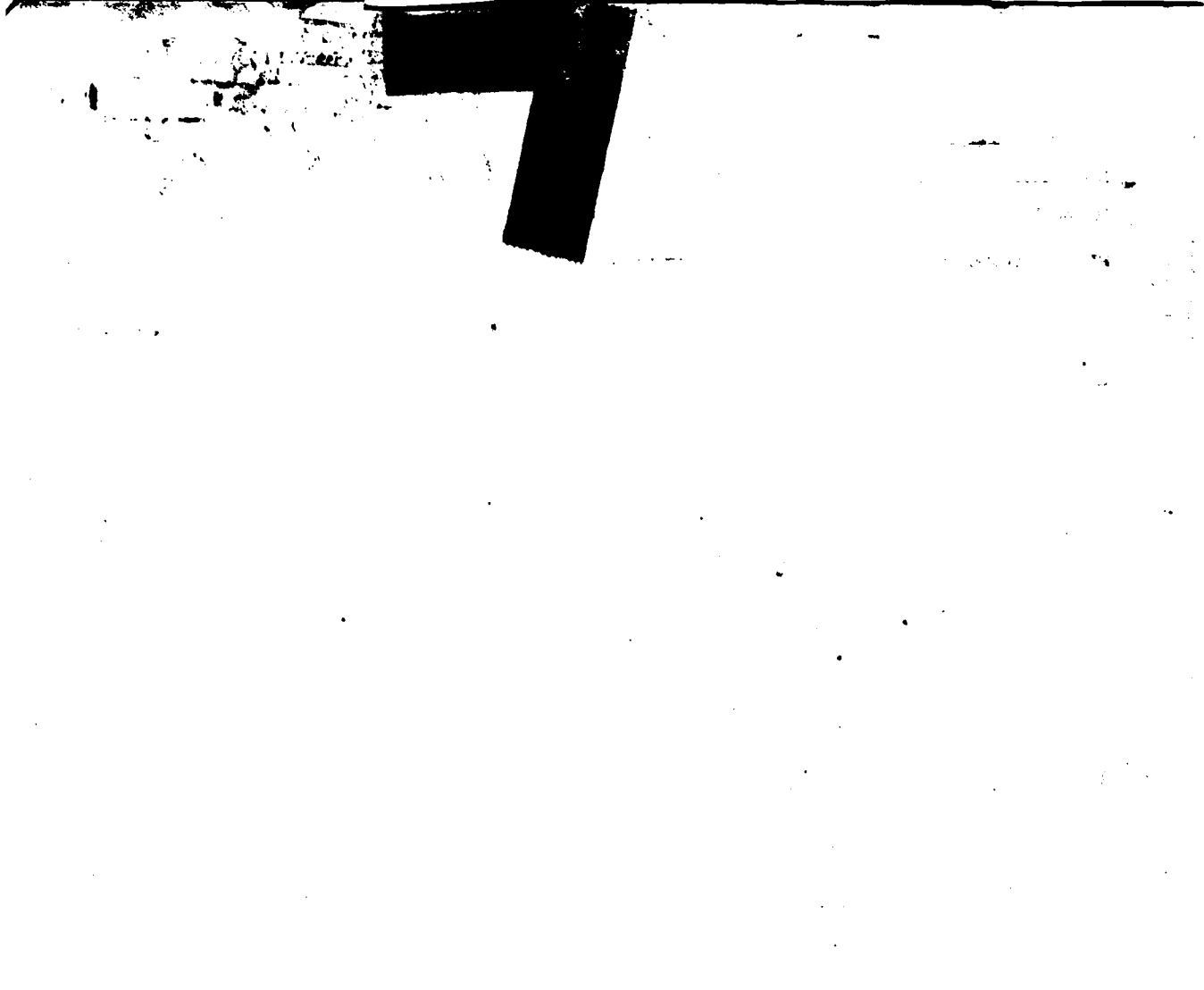
Give names added from a supplemental report.

_____, 192_____

Registrar.

Address Priest River, Ida.Filed Feb 1 1924

Registrar.



1. PLACE OF DEATH

County of Bonneville Registration District No. 20
City of Post River Primary Registration District No. 2001
(No. St.)File No. 3
Registered No. 86

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Daggett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m. 4. COLOR OR RACE w. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Jan 13 1924
(Month) (Day) (Year)

7. AGE

— Yrs. — Mos. — ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. none
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

William Daggett

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Alice Lithgow

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Mrs. Mary Daggett

15.

Filed Jan 13 1924

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 13 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw him alive on 19
and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Still Birthcause: Syphilis(Duration) — Yrs. — mos. — ds.Contributory
(Secondary)(Duration) — yrs. — mos. — ds.

(Signed)

M. D.

Jan 13 1924

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Post RiverJan 13 1924

20. UNDERTAKER

ADDRESS

Wm. DaggettPost RiverIdaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

S

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

118664

County of Bingham City of Blackfoot
 No. RD # 5 St. Registration District No. 121 State File No. 118664
 Hospital 492 119 006 866 Primary Registration District No. 2 Local Registrar's No. 16
 FULL NAME OF CHILD Mitchell

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet 4 and { Number in order of birth 5 } Legitimate? yes Date of birth Jan 19 1924
 (To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 7Number of child of this mother now living, including present birth 1

FATHER
 FULL NAME Leonard H. Mitchell
 RESIDENCE Blackfoot
 COLOR White AGE AT LAST BIRTHDAY 39 (Years)
 BIRTHPLACE Utah
 OCCUPATION Farming

MOTHER
 FULL MAIDEN NAME Alice Howcroft
 RESIDENCE Blackfoot
 COLOR White AGE AT LAST BIRTHDAY 37 (Years)
 BIRTHPLACE Utah
 OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive 4 9 M.
 on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician ~~and wife~~)

Address

Filed

1924

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
 N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

100

100

100

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bingham State of Idaho District No. 124
 City of Blackfoot (No. 11) Registration District No. 2194 (St.) Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Full name Mitchell

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 44375
 Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Boy 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH Jan 19 1924
 (Month) (Day) (Year)

7. AGE Speltborn IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Lernard H. Mitchell

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Alice Howcroft

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. H. Mitchell

(Address) Blackfoot #15

15. Filled Jan 21 1924 by Wm. W. Beck Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 19 1924
 (Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from Jan 19 1924 to Jan 19 1924 that I last saw him alive on Dec 19 1923 and that death occurred on the date stated above, at 11 A M. The CAUSE OF DEATH* was as follows:

Protrusion of cord

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. W. Beck M. D.
1/21/1924 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Thomas - Riverside Cem Jan 22 1924

20. UNDERTAKER

ADDRESS

L. H. Mitchell

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. R.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

213 124 206-154
PLACE OF BIRTH

RECEIVED
JAN 10 7 1924
BUREAU OF VITAL STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bingham
City of Blackfoot
No. RA 3 St. Registration District No. 121 State File No. 118665
Hospital Blackfoot Primary Registration District No. 2194 Local Registrar's No. 17
FULL NAME OF CHILD August Joseph Salverson
(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? 5 and { Number in order of birth 5 } Legitimate? yes Date of birth Jan 24 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth <u>7</u>		Number of child of this mother now living, including present birth <u>5</u>	
FATHER	MOTHER	FATHER	MOTHER
FULL NAME <u>William J. Salverson</u>	FULL MAIDEN NAME <u>Florence Anderson</u>	FULL NAME <u>William J. Salverson</u>	FULL MAIDEN NAME <u>Florence Anderson</u>
RESIDENCE <u>Blackfoot</u>	RESIDENCE <u>Blackfoot</u>	RESIDENCE <u>Blackfoot</u>	RESIDENCE <u>Blackfoot</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>41</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>37</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>41</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>37</u> (Years)
BIRTHPLACE <u>Utah</u>	BIRTHPLACE <u>Utah</u>	BIRTHPLACE <u>Utah</u>	BIRTHPLACE <u>Utah</u>
OCCUPATION <u>Farming</u>	OCCUPATION <u>Housewife</u>	OCCUPATION <u>Farming</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at Blackfoot M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) W. W. Beck
(Physician or midwife)

Address Blackfoot
Filed Feb. 5 1924 Wm. Waters Registrar.

Registrar.

DECLASSIFICATION OF RECORDS

DATE OF REVIEW: 10/10/2000
BY: [illegible]

Spice, [illegible]

As a result of this review, it was determined that the records are not subject to automatic declassification.

DECLASSIFICATION OF RECORDS

1. The records are not subject to automatic declassification.
2. The records are not subject to automatic declassification.
3. The records are not subject to automatic declassification.
4. The records are not subject to automatic declassification.
5. The records are not subject to automatic declassification.
6. The records are not subject to automatic declassification.
7. The records are not subject to automatic declassification.
8. The records are not subject to automatic declassification.
9. The records are not subject to automatic declassification.
10. The records are not subject to automatic declassification.

STATE OF IDAHO.
DEPARTMENT OF PUBLIC WELFARE.

Dear Madam:

Boise, Idaho FEB 1 1923.

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY Blackfoot
ST. _____
COUNTY Idaho
FATHER William T. Saberson
MOTHER F. Irene Saberson
(Maiden Name)

FILE NO. 118665
DATE OF BIRTH Jan. 26, 1924
SEX OF CHILD Male boy

I HEREBY CERTIFY that the child herein described has been named:

August Joseph Saberson

W. T. Saberson

Signature of Father or Mother.

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VETERINARY MEDICINE

Boiler

1911

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bingham
City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
1924
VITALS

CERTIFICATE OF DEATH

Registration District No. 2194
Primary Registration District No. 2194
(No. _____ St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 44377
Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Jan 24 1924
(Month) (Day) (Year)

7. AGE

31 yrs. 10 mos. 15 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

William T. Salverson

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Florence Anderson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. T. Salverson

(Address)

Blackfoot Idaho

15.

Filed

Jan 25 1924 W. T. Salverson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 24 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 24 1924 to Jan 24 1924
that I last saw h. _____ alive on Dec 19 1923

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Hydrocephalus and premature

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W. T. Salverson M. D.1/24/24(Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Green City Cemetery 1/25 1924

20. UNDERTAKER

ADDRESS

E. J. P. P. Blackfoot

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

53-229-609-662
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

FEB 1 1924

CERTIFICATE OF BIRTH **S 118692**

County of **Bonner**

City of **Priest River,**

No. _____ St. _____

Registration District No. **85**

File No. **6**

Hospital **Priest River Hospital**

Registration District No. **2185**

Registered No. **320**

FULL NAME OF CHILD **Ethel Peterson**

(Certificate of no value without full name of child.)

Sex of Child F.	Twin Triplet or other? { and { Number in order of birth	Legitimate? Yes	Date of birth Jan 29 1924 (Month) (Day) (Year)
------------------------	---	------------------------	--

What bacteriocidal solution was used in eyes? **none**

Number of child of this mother, including present birth _____ Number of child of this mother now living, including present birth _____

FATHER
FULL NAME **Chester H. Peterson.**
RESIDENCE **Priest River, Idaho.**
COLOR **W.** AGE AT LAST BIRTHDAY **29** (Years)
BIRTHPLACE **N. Dakota.**
OCCUPATION **Mechanic.**

MOTHER
FULL MAIDEN NAME **Maud Foster**
RESIDENCE **Priest River, Idaho.**
COLOR **W.** AGE AT LAST BIRTHDAY **27** (Years)
BIRTHPLACE **N. Dakota.**
OCCUPATION **Housewife.**

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was **Stillborn** at **6 P.M.** on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) _____

C. F. Gatzert

(Physician or midwife)

Give names added from a supplemental report.
_____, 19_____

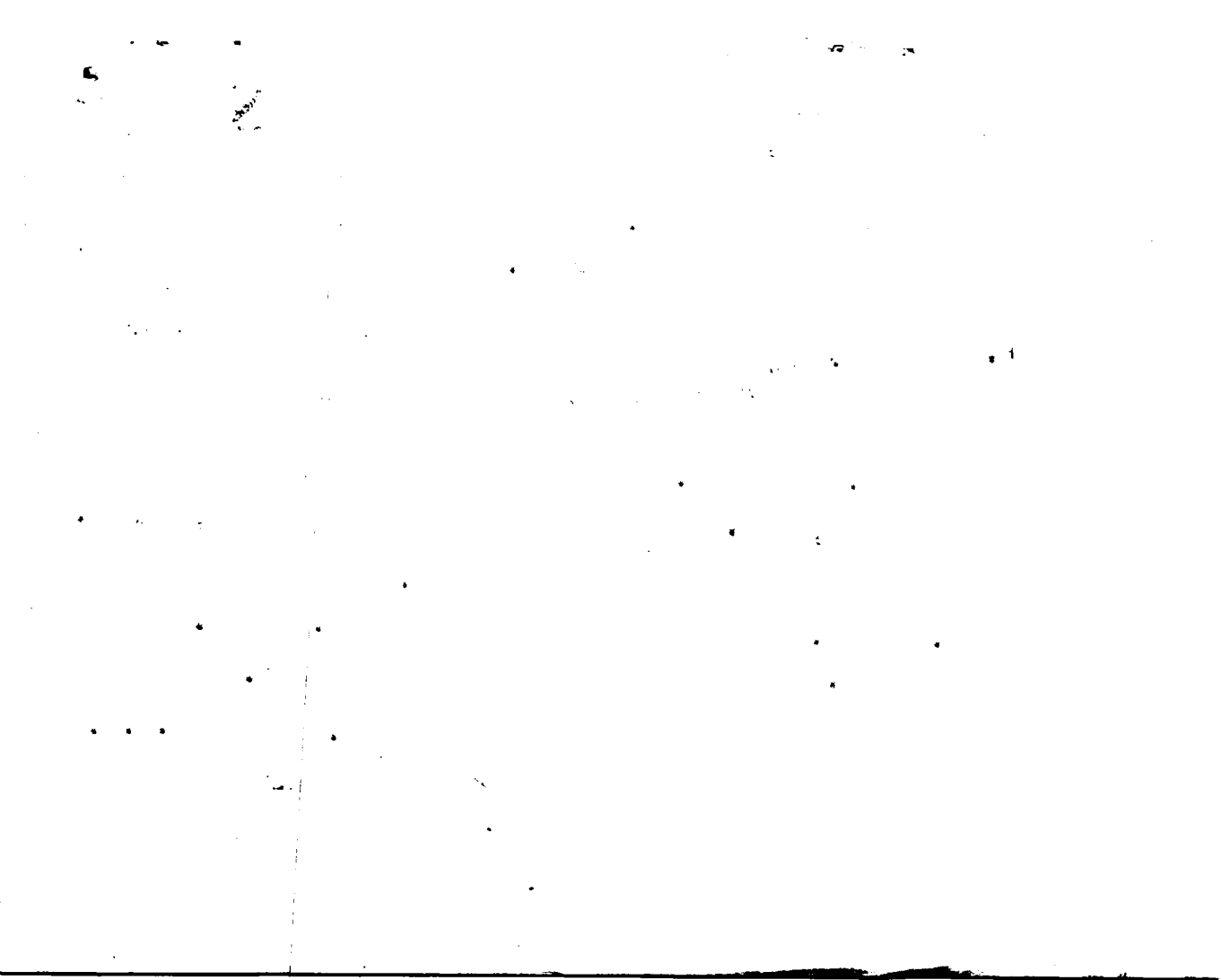
Registrar.

Address _____

Filed **Feb 1 1924**

C. F. Gatzert

Registrar.



1924

CERTIFICATE OF DEATH

44379

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner
City of Priest RiverBUREAU OF VITAL STATISTICS
Registration District No. 85
Primary Registration District No. 2185File No. _____
Registered No. 100

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ethel Peterson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Jan 29 1924
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).None

9. BIRTHPLACE

(State or Country)

Priest River, Ida,

10. NAME OF FATHER

Chester Paterson

11. BIRTHPLACE OF FATHER

(State or Country)

N.D.

12. MAIDEN NAME OF MOTHER

Maud Foster,

13. BIRTHPLACE OF MOTHER

(State or Country)

N.D.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Chester A. Peterson
Priest River, Ida.

15.

Filed

Feb 1 1924

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 29 1924
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 29 1924 to Jan 29/24 1924, that I last saw her alive on Not 1924, and that death occurred on the date stated above, at am M. The CAUSE OF DEATH* was as follows:Still birth at Six months.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

Jan 29 1924 (Address) Priest River, Ida,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Priest RiverJan 30 1924

20. UNDERTAKER

ADDRESS

Chester Peterson Father PriestRiver, Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

962-122009-256

STATE OF IOWA
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Banner
City of Westmond
No. _____ St. _____ Registration District No. 76 File No. **S 118701**
Hospital _____ Primary Registration District No. 2155 Registered No. _____

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child M. Twin Triplet or other? _____ and Number in order of birth _____ Legiti- mate? yes Date of birth 1-12 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bacteriocidal solution was used in eyes? None

Number of child of this mother, including present birth... 6 Number of child of this mother now living, including present birth... 6

FATHER
FULL NAME Fred L. Robinson
RESIDENCE Westmond
COLOR white AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Iowa
OCCUPATION Planer

MOTHER
FULL MAIDEN NAME Grace Ellen Smedgrass
RESIDENCE Westmond
COLOR white AGE AT LAST BIRTHDAY 40 (Years)
BIRTHPLACE Jefferson Co - Ill.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 1 - A. M. on the date above stated. (Born ~~alive~~ stillborn)

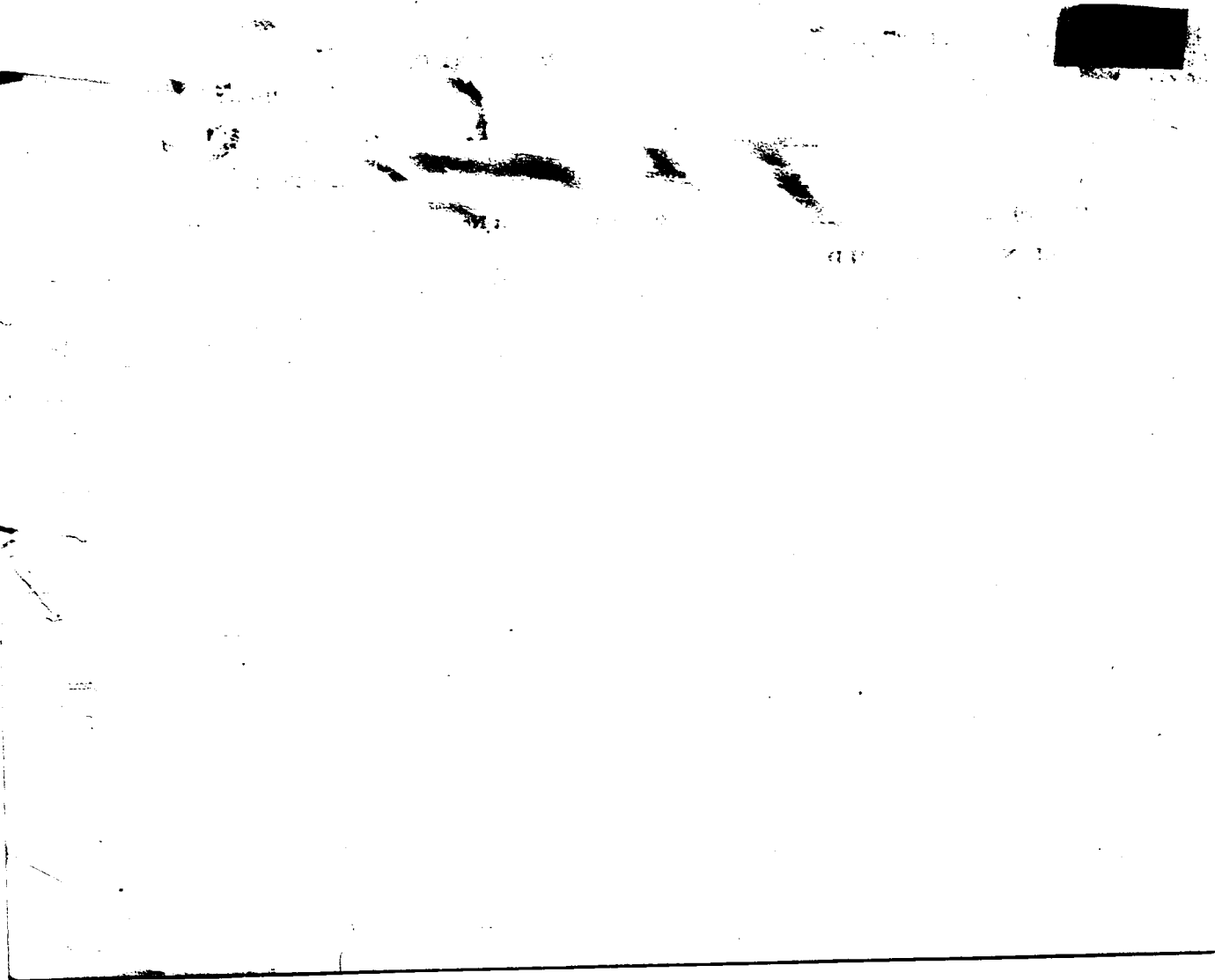
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) C. P. Staasch
MD
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address Saupeau
Filed Feb 2 1924 Viola Alders
deputy Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-18

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 44651

1. PLACE OF DEATH MAINE Registration District No. 78
County of _____ Primary Registration District No. 2155
City of _____ (No. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

UnnamedRobison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Male White

(Write the word.)

6. DATE OF BIRTH.

Jan 22 1924

(Month)

(Day)

(Year)

7. AGE

Stillborn

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min. >

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Westmond Idaho

10. NAME OF FATHER

Fred L. Robison

11. BIRTHPLACE OF FATHER

(State or Country)

Ida.

12. MAIDEN NAME OF MOTHER

Grace Ellen Snodgrass

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

O. P. Stachan

(Address)

Sandpoint

15.

Filed

Feb 21924Viola Allen

Local Registrar

Deputy

16. DATE OF DEATH

Probably Jan 10 - 12 days before birth

(Month)

(Day)

191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
191 to 191

that I last saw h. alive on 191
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Torsion of cord - 3 complete revolutions required to straighten cord

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O. P. Stachan M. D.7/2 1924 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days In the State. yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as *fracture of skull*, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

County of

City of

No. 1109-85850

Hospital 213-12304-236

FULL NAME OF CHILD

RECEIVED

FEB 1 1924

BUREAU OF VITAL STATISTICS

Registration District No.

Primary Registration District No. 1086

Local Registrar's No.

(Certificate of no value without full name of child)

Sex of Child

Twin
Triplet
or other?

and

Number
in order
of birthLegiti-
mateDate of
birth

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FULL
NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

FULL
MAIDEN
NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 3:50 P. M.
on the date above stated.

(Signature)

(Physician or midwife)

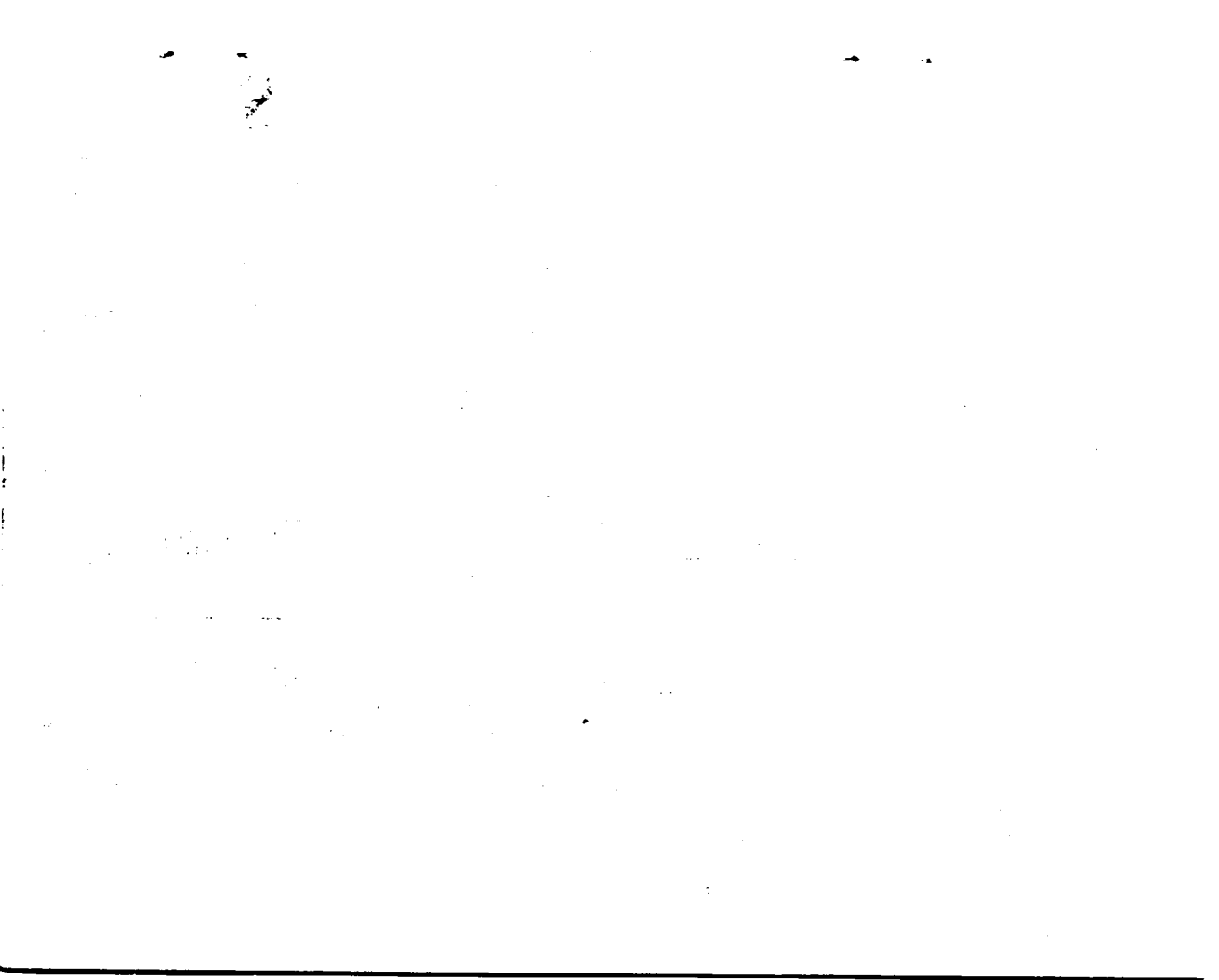
Address

Filed

Registrar.

Registrar.

N. B.—In case of more than one child at birth a SEPARATE RETURN is to be made for each and the number of each, in order of birth stated.



FORM V. S. No. 5-A-25M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Canyon
City of Hampton

Registration District No. 7

Primary Registration District No. 1006

State File No. 44404

Local Registrar's No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Baldwin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M

white

(Write the word)

6. DATE OF BIRTH

Jan 23 1924
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many hrs. or min.?

✓ Yrs. ✓ Mos. ✓ ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF Father

Ben L Baldwin

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Mary Sloper

13. BIRTHPLACE OF MOTHER

(State or Country)

Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ben L Baldwin

(Address)

109 8th St

15.

Filed

Feb 11 1924

1924

Charles Dodd
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 23 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1924 to Jan 23 1924

that I last saw h. Stillborn 1924, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still-born
Hydro Cephalus
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo W Chittas M. D.
1/29/24 (Address) Hampton Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Robt. L. L. L.

12/24 1924

20. UNDERTAKER

ADDRESS

Robt. L. L. L.
Hampton

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.**, **Carcinoma, Carcoma, etc.**, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

766-030-014962

RECEIVED

County of

Canyon

FEB 1 1924

City of

Harrison

Registration District No.

7

File No.

118753

No.

St.

Primary Registration District No.

1052

Registered No.

Hospital

FULL NAME OF CHILD

Good.

Sex of Child

Male

Twin
Triplet
or other?
(To be answered only in event of plural births)

and

(Number
in order
of birth)Legiti-
mate? yesDate of
Birth

1-30

24

FULL
NAME

Daniel Wm Good

FATHER

FULL
MAIDEN
NAME

Sarah Ross

MOTHER

RESIDENCE

Harrison

RESIDENCE

Harrison

COLOR

White

AGE AT LAST
BIRTHDAY45
(Years)

COLOR

White

AGE AT LAST
BIRTHDAY43
(Years)

BIRTHPLACE

Ill.

BIRTHPLACE

Mo

OCCUPATION

Janitor

OCCUPATION

House Wife

Number of child of this mother, including present birth

12

Number of children of this mother now living, including present birth

5

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was
on the date above stated.

*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

Stillborn 1:30 P
C.R. Meredith

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Filed

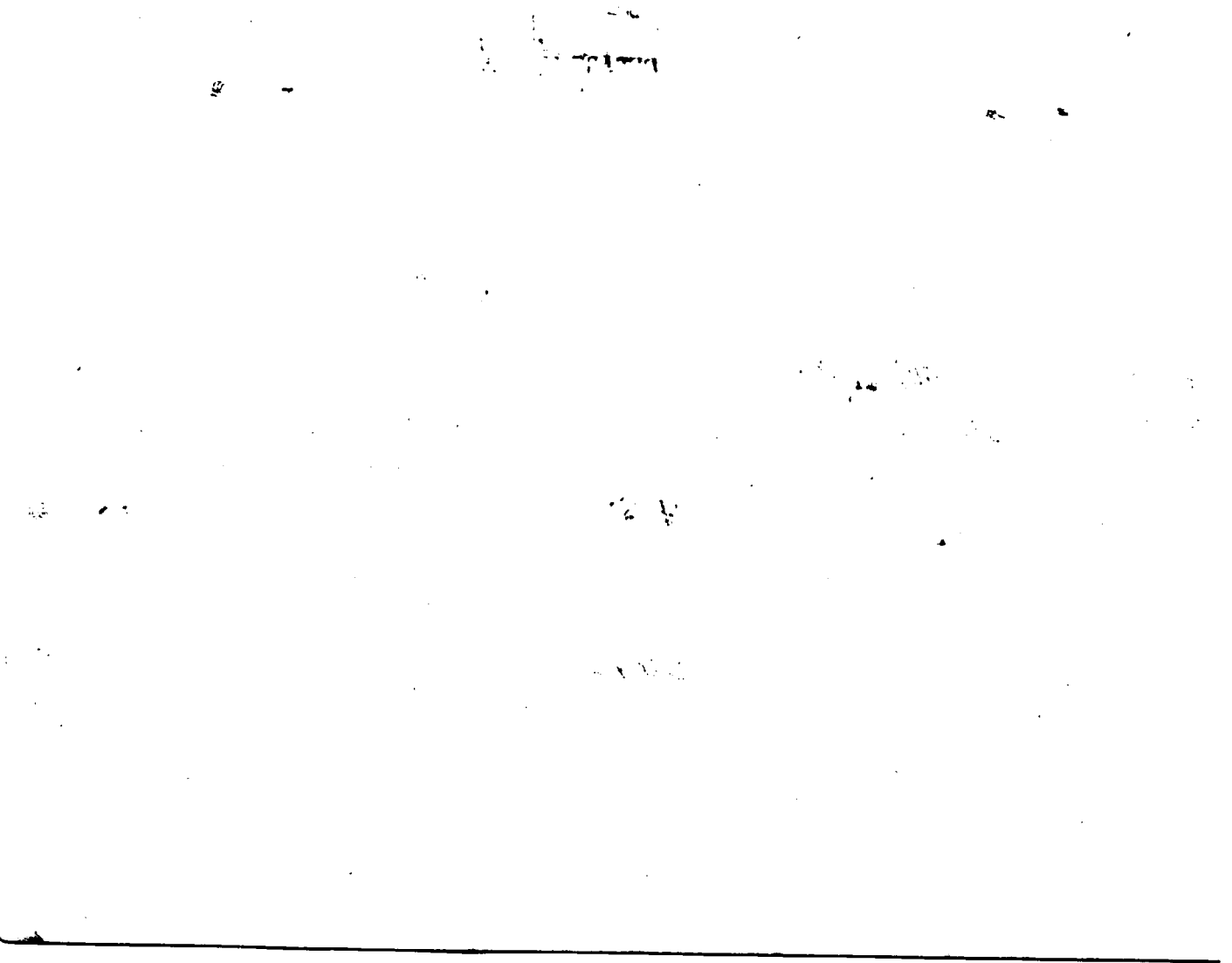
Feb 4

1924

Pearle Dodds

Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH **RECEIVED FEB 7 1924**
 Registration District No. 7
 County of Canyon Primary Registration District No. 1006
 City of Hamlet (State) Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Good

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 44414

Registered No. _____
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Indeterminate 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
 (Write the word.)

6. DATE OF BIRTH Jan 30 1924
 (Month) (Day) (Year)

7. AGE Premature IF LESS than 1 day
 how many hrs. or mins.?

8. OCCUPATION
 (a) Trade, profession or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Nampa Idaho
 (State or Country)

10. NAME OF FATHER Daniel Wm Good

11. BIRTHPLACE OF FATHER Ill. Ill.
 (State or Country)

12. MAIDEN NAME OF MOTHER Sarah Ann Ross

13. BIRTHPLACE OF MOTHER Wilo Mo
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) C. R. Meredith
 (Address) Nampa

15. Filed Feb 4 1924 Pearle Dodge
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Previous to Birth 1924
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191____ to 191____
 that I last saw him alive on 191____
 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Heart and Lungs
and flowing gas
 (Duration) yrs. mos. ds.
 Contributory (Secondary)
 (Duration) yrs. mos. ds.
 (Signed) M. D.
 19 (Address)

*State the DISEASE CAUSING DEATH or in death from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACID, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)
Reported By C. R. Meredith M.D.
 at place of death yrs. mos. days. In the State yrs. mos. days.
 Where was disease contracted if not at place of death? Nampa Idaho
 Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Nampa Idaho Jan 30 1924

20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of FranklinCity of PrestonNo. 235 714 021 695St. Registration District No. 27

State File No.

Hospital

BUREAU

Primary Registration District No. 2119Local Registrar's No. 4

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child)

Sex of Male
ChildTwin
Triplet
or other?{ and { Number
in order
of birth
(To be answered only in event of plural births)Legiti-
mate? YesDate of
birth 1-14192 4

(Month) (Day) (Year)

What bactericidal solution was used in eyes? 20% Ag.Number of child of this mother, including present birth 5Number of child of this mother now living, including present birth 4FULL
NAME

FATHER

Samuel StephensenFULL
MAIDEN
NAME

MOTHER

Irene Winward

RESIDENCE

Preston, Idaho

RESIDENCE

Preston, Idaho

COLOR

WhiteAGE AT LAST
BIRTHDAY 38
(Years)

COLOR

WhiteAGE AT LAST
BIRTHDAY 32
(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Idaho

OCCUPATION

Dist. Foremen Utah Power & Light

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn ^{Dead-Alive} at 12:40 A M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Physician

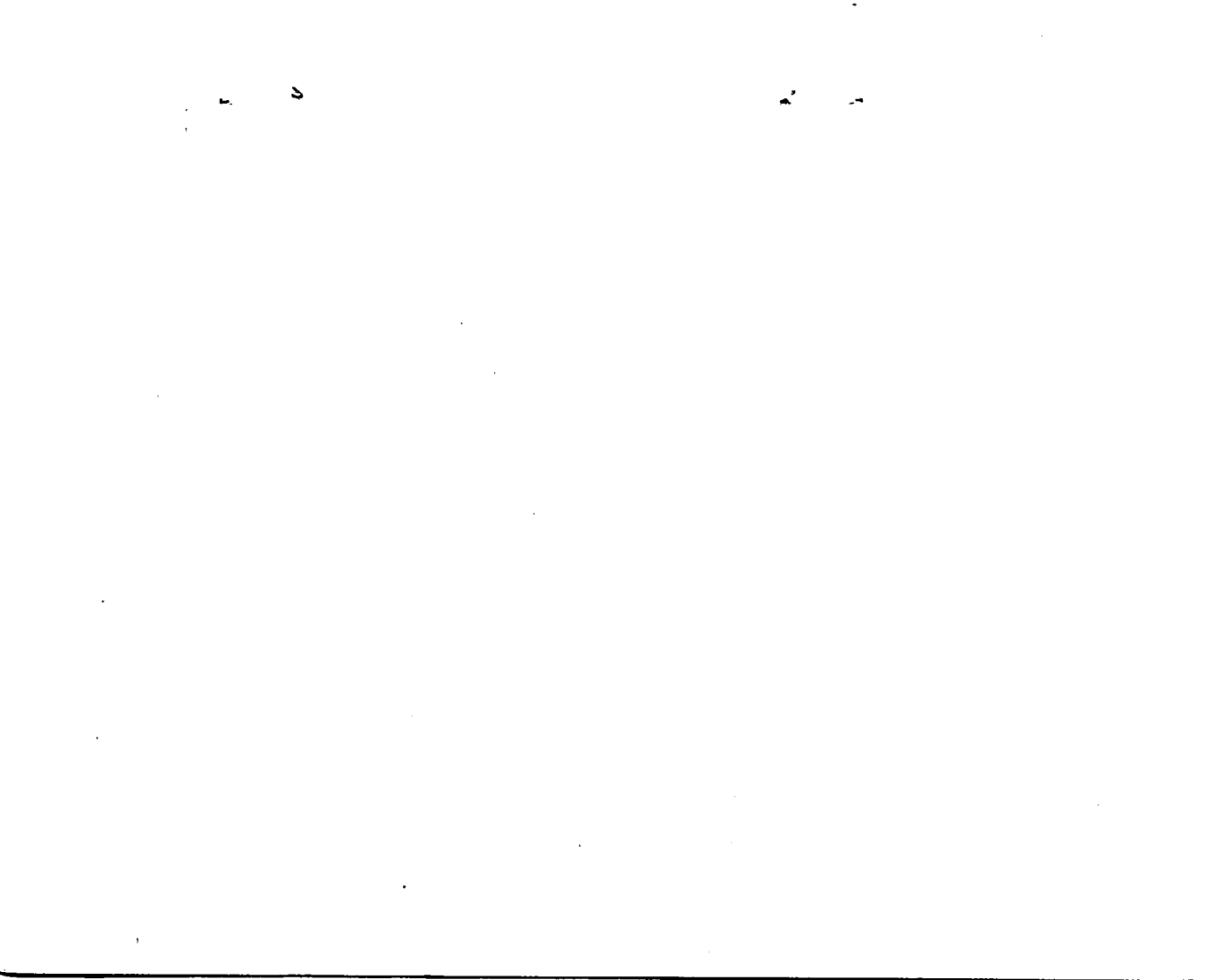
(Physician or midwife)

Address Preston, IdahoFiled 2-4 1924

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of FranklinCity of Preston

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME Stillborn

Registration District No. 27
BUREAU OF Registration District No. 2119
STATISTICS St.)

File No. 44431
Registered No. 7

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Jan. 14 1924
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many..... hrs.
Yrs. Mos. ds. or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Samuel Stephensen

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Irene Winward

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samuel Stephensen(Address) Preston, Idaho

15.

Filed 2/-4 1924

Mrs. H. L. Lipsett
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 14 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw h Stillborn alive on 1240
and that death occurred on the date stated above, at 1240 M.

The CAUSE OF DEATH* was as follows:

Asphyxia

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

1/15 24(Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place Life In the Life
of death yrs. mos. days. State yrs. mos. days

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Preston, Idaho

DATE OF BURIAL

1/14 1925

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of FranklinCity of PrestonNo. 595-206021-389St. Registration District No. 27 State File No. 118803Hospital Stillborn Primary Registration District No. 2119 Local Registrar's No. 2

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child	<u>Female</u>	Twin Triplet or other?	<u> </u>	and	Number in order of birth	<u> </u>	Legiti- mate?	<u>yes</u>	Date of birth	<u>Jan 6 1924</u>
										(Month) (Day) (Year)

What bactericidal solution was used in eyes? 20% Ar.Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4FULL
MAIDEN
NAME

FATHER

Harold E. Niel

RESIDENCE

Preston, Idaho

COLOR

WhiteAGE AT LAST
BIRTHDAY35

(Years)

BIRTHPLACE

England

OCCUPATION

LaborerFULL
MAIDEN
NAME

MOTHER

Myrtle Christensen

RESIDENCE

Preston, Idaho

COLOR

WhiteAGE AT LAST
BIRTHDAY30

(Years)

BIRTHPLACE

Utah

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 6:30 P M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

A. R. Cutler
Physician

(Physician or midwife)

Address

Preston, Idaho

Filed

Feb. 4, 1924

Registrar.

Registrar.

2

12 11

12 11

1

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 44430
Registered No. 3

1. PLACE OF DEATH

County of FranklinCity of Preston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stillborn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-

OWED OR DIVORCEDSingle

(Write the word.)

6. DATE OF BIRTH

Jan. 6 1924
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Harold E. Neil

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Myrtle Christensen

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harold E. Neil(Address) Preston, Idaho

15.

Filed 2-4 1924

Mrs. Ida Lippel
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 6 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Stillborn 19

that I last saw him alive on 19

and that death occurred on the date stated above, at 6:30 M.

The CAUSE OF DEATH* was as follows:

Bright's disease of
mother

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

1/7 24(Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Life yrs. mos. days. In the Life State Life yrs. mos. days.

Where was disease contracted if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Preston, Idaho

DATE OF BURIAL

1/7 1924

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

County of Gem

FEB 7 1924

BUREAU OF VITAL STATISTICS

City of Emmett

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. 243124023118

St. Registration District No. 6

State File No. S 118842

Hospital

Primary Registration District No.

Local Registrar's No.

FULL NAME OF CHILD

Paul Nathaniel Butcher
(Certificate of no value without full name of child)

Sex of Child

male

Twin
Triplet
or other?

— } and {

Number
in order
of birth

—

Legiti-
mate?

yes

Date of
birth

1-24

1924

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

none

Number of child of this mother, including present birth

5

Number of child of this mother now living, including present birth

4

FULL
NAME

FATHER

Logan R Butcher

RESIDENCE

Emmett

COLOR

white

AGE AT LAST
BIRTHDAY

33

(Years)

BIRTHPLACE

Okla.

OCCUPATION

Preacher

FULL
MAIDEN
NAME

MOTHER

Della Lee Jay

RESIDENCE

Emmett

COLOR

white

AGE AT LAST
BIRTHDAY

33

(Years)

BIRTHPLACE

Texas

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 7:45 a M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Benton O. Clark

(Physician or midwife)

Give names added from a supplemental report.

Address

Filed

2-7-1924

Registrar.

Registrar.

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE NATURALIZATION ACT ONLY AND IS NOT VALID FOR ANY OTHER PURPOSE. IT IS NOT VALID FOR THE PURPOSES OF THE NATURALIZATION ACT OF 1906 OR 1908.

PLACE OF BIRTH

County of _____
State of _____

1911

CERTIFICATE OF BIRTH

No. _____
Date of birth _____
Place of birth _____

FULL NAME OF CHILD

(Certificate of _____ without the name of child)

Sex of child _____
Color _____
Date of birth _____
Month _____ Day _____ Year _____
(To be answered only in case of illegitimacy)

What bacteriological solution was used in eyes?

Number of child of this mother including present birth _____
Number of child of this father including present birth _____

FATHER
NAME _____
RESIDENCE _____
MOTHER
NAME _____
RESIDENCE _____

AGE AT LAST BIRTHDAY _____
COLOR _____
BIRTHPLACE _____
OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____
Signature _____
Physician or midwife

Give names added from a supplemental report.
When there was no attending physician or midwife, then the father, household or mother, make this return. A statement that is one that neither prescribes nor shows other evidence of the birth.

Address _____
Date of registration _____
Registration _____

STATE OF IDAHO.
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho FEB 1 1924 1924

RECEIVED
FEB 26 1924
BUREAU OF VITAL
STATISTICS

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY Emmett
ST. 1024 S. Washington.
COUNTY Gem
FATHER L. R. Butcher
FILE NO. 118842
DATE OF BIRTH Jan. 25/1924.
SEX OF CHILD Male
MOTHER Della Lee Jay
(Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Paul Nathaniel

L. R. Butcher

Signature of Father or Mother

1900



RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 44438

1. PLACE OF DEATH

County of Gem

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Son of R. R. Butcher

Registration District No.

Primary Registration District No. 6

St.)

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-

OWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

Jan 24 1924
(Month) (Day) (Year)

7. AGE

new Born
Yrs. Mos. ds.

IF LESS than 1 day

how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

R. R. Butcher

11. BIRTHPLACE OF FATHER

(State or Country)

Oklahoma

12. MAIDEN NAME OF MOTHER

Della Lee Jay

13. BIRTHPLACE OF MOTHER

(State or Country)

Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. R. Butcher

(Address)

Emmett Idaho

15.

Filed

1/24

19 24

J. R. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 24 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at 7:40 P.M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Burton O. Clark M. D.

1/24 1924

(Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Emmett Ida

DATE OF BURIAL

1/25 1924

20. UNDERTAKER

O. Bucknum

ADDRESS

Emmett Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

1732

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

154227 033 433

County of Madison

City of Thomton

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

RECEIVED

FEB 11 1924

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

118963

No. _____ St. ~~Registration~~ District No. 160 State File No. _____

Hospital _____ Primary Registration District No. 2178 Local Registrar's No. 686

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and {	Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>1-27-1924</u>
(To be answered only in event of plural births)				(Month)	(Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Wells M. Harrison
RESIDENCE Thomton
COLOR White AGE AT LAST BIRTHDAY 22 (Years)
BIRTHPLACE Idaho
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Helma M. Cutler
RESIDENCE Thomton
COLOR White AGE AT LAST BIRTHDAY 21 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 6 a. m. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) John H. Rich

(Physician or midwife)

Address Reboing Idaho

Filed 31 192 4

Registrar.

Registrar.

THE UNIVERSITY OF CHICAGO

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho FEB 1 1924 1923.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth (CITY Thornton FILE NO. 118963
(ST. _____ DATE OF BIRTH January 27, 1924.
(COUNTY Madison SEX OF CHILD Female
FATHER Otto M. Anderson MOTHER Leatha McIntier
(Maiden Name)

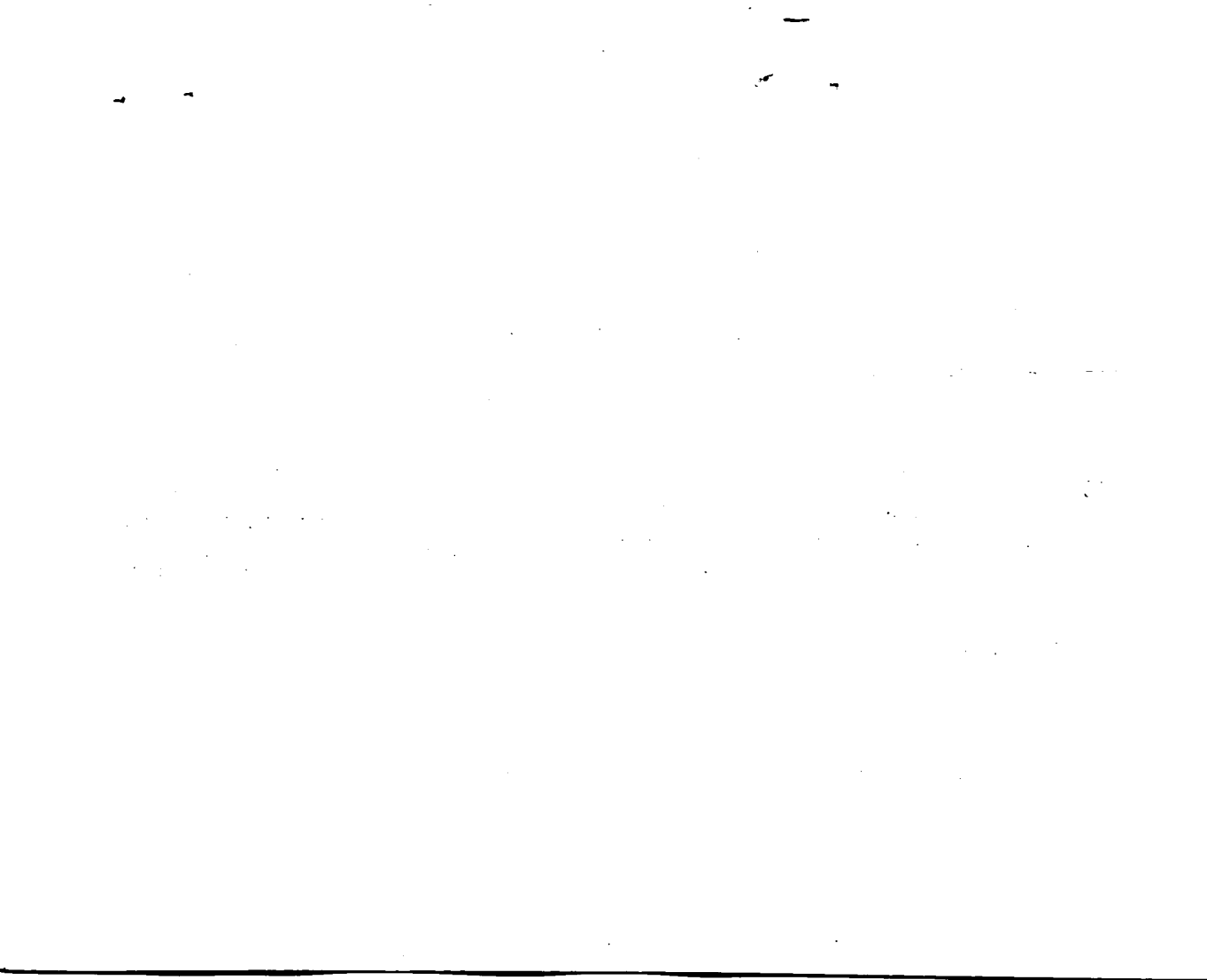
I HEREBY CERTIFY that the child herein described has been named:

No name given baby born dead

Leatha Anderson.

Signature of Father or Mother.

RECEIVED
3 - 1924
BUREAU OF VITAL
STATISTICS



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Madison
City of Thonton

Registration District No. 100
Primary Registration District No. 2178
(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 44819
Registered No. 101

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Born
(Write the word.)

6. DATE OF BIRTH. Jan 27 1924
(Month) (Day) (Year)

7. AGE 2 IF LESS than 1 day how many hrs. or min. 2
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Babe

9. BIRTHPLACE

(State or Country)

Thonton Ida

10. NAME OF FATHER

Otto Anderson Jr

11. BIRTHPLACE OF FATHER

(State or Country)

Thonton Ida

12. MAIDEN NAME OF MOTHER

Leatha M. Intyre

13. BIRTHPLACE OF MOTHER

(State or Country)

Thonton

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Frank McFale

(Address)

Thonton Ida

15.

Filed

Feb 20

191 24

Myong

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 27 191 24
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 191 24 to Jan 27 191 24, that I last saw her Jan 27 191 24 and that death occurred on the date stated above, at 11 M.

The CAUSE OF DEATH* was as follows:

Arrhythmia of heart
(Collapsed before birth)
No pulsation

(Duration) Stillborn Yrs. mos. ds.

Contributory (Secondary)

(Duration) 1 yr 5 mos Yrs. mos. ds.

(Signed)

John S. Smith M. D.

115 1924 (Address) Keokuk Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Archie County

DATE OF BURIAL

Feb 2 191 24

20. UNDERTAKER

None

ADDRESS

None

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Modoc

FEB 11 1924

City of Reynolds

BUREAU OF CERTIFICATE OF BIRTH
STATISTICS

No. 219 231 033 218

Registration District No. 100

State File No.

118968

Hospital

Primary Registration District No. 2178

Local Registrar's No. 691

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

Female

Twin
Triplet
or other?

} and {

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

Yes

Date of
birth

Jan. 31 1924
(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 6

Number of child of this mother now living, including present birth 3

FULL
NAME

FATHER

Frederic Barrett

RESIDENCE

Reynolds

COLOR

W

AGE AT LAST
BIRTHDAY

34

(Years)

BIRTHPLACE

Ida.

OCCUPATION

Plumber

FULL
MAIDEN
NAME

MOTHER

Elise Ballif

RESIDENCE

Reynolds

COLOR

W

AGE AT LAST
BIRTHDAY

35

(Years)

BIRTHPLACE

Utah

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at Reynolds on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

H. B. Reynolds

(Physician or midwife)

Give names added from a supplemental report.

, 192

Registrar.

Address

Filed

31

192

W. C. Ryan

Registrar.

1. If the child is born to a woman who is not a resident of this State, the birth of the child shall be reported to the Registrar of Births and Deaths by the person who is the father of the child, or by the mother of the child, or by the person who is the guardian of the child, or by the person who is the person in charge of the institution in which the child is born, or by the person who is the person in charge of the hospital in which the child is born, or by the person who is the person in charge of the place in which the child is born.

(Give names which form a supplemental report.
 *When there was no attending physician or midwife, then the father, householder, or other person who is the person in charge of the household, or the person who is the person in charge of the institution in which the child is born, or the person who is the person in charge of the hospital in which the child is born, or the person who is the person in charge of the place in which the child is born, shall report the birth of the child to the Registrar of Births and Deaths.

I hereby certify that I attended the birth of the child, who was born on the date above stated.
 (Signature)
 (Physician or midwife)

OCCUPATION
 BIRTHPLACE
 COLOR
 AGE AT LAST BIRTHDAY

FULL NAME
 FATHER
 FULL NAME
 MOTHER

Number of child of wife mother now living (including present birth)
 (To be answered only in event of plural birth)
 Sex of child
 Date of birth
 Month
 Year

(Certificate to be filled in without reference of child)
 PLACE NAME OF CHILD

COUNTY OF
 CITY OF
 STATE OF

DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH
 118368

REGISTERED

STATE OF IDAHO.

DEPARTMENT OF PUBLIC WELFARE.

Dear Madam:

Boise, Idaho FEB 14 1924 1923.

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

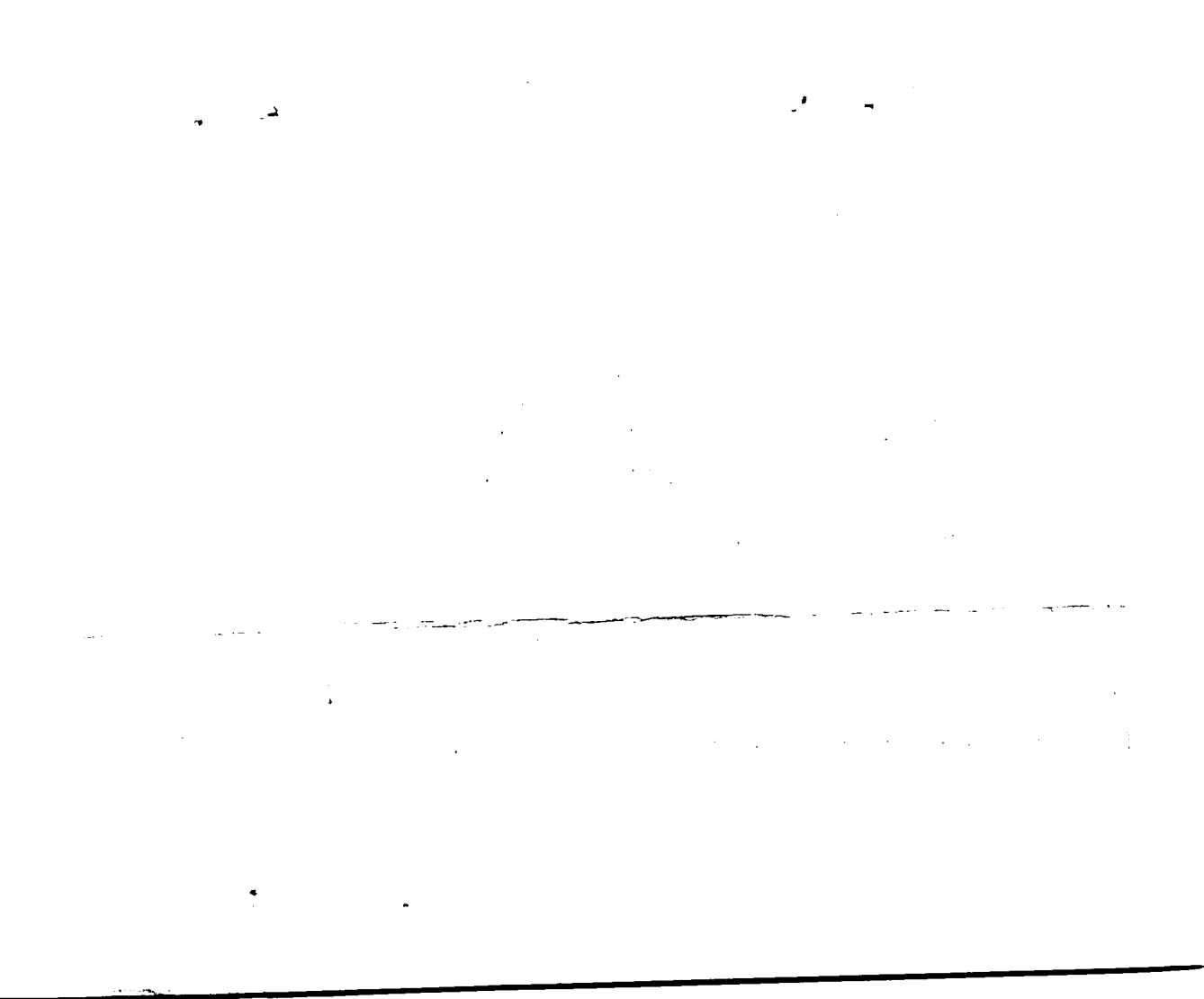
Place of Birth (CITY Reburg FILE NO. 118968
 (ST. 1st S. + 1st East. DATE OF BIRTH Jan. 31, 1924
 (COUNTY Madison SEX OF CHILD Female
 FATHER Fred Barrett MOTHER Clise Balliff
 (Maiden Name)

I HEREBY CERTIFY that the child herein described has been named:

Baby was a still birth and not named.

RECEIVED
 FEB 2 1924
 BUREAU OF VITAL STATISTICS

Mrs Fred Barrett
 Signature of Father or Mother.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH

County of *Bradwin*City of *Reynolds*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Barrett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Born
(Write the word.)

6. DATE OF BIRTH.

Jan 31 1924
(Month) (Day) (Year)

7. AGE

*Yrs. Mos. ds.*IF LESS than 1 day
how many hrs. or
..... min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Reynolds Idaho

10. NAME OF FATHER

Fred Barrett

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Elise Balliff

13. BIRTHPLACE OF MOTHER

(State or Country)

Lyon Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Fred Barrett

(Address)

Reynolds Idaho

15.

Filed *2/1**1924**Physician*
Local Registrar

CERTIFICATE OF DEATH.

RECEIVED
FEB 1 1924
BUREAU OF VITAL STATISTICSRegistration District No. *108*Registration District No. *2178*

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *44490*Registered No. *2178*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 31 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Jan. 31 1924 to Jan. 31 1924*that I last saw him alive on *Reynolds 1924*and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Large growth (tumor) right side of neck.(Duration) *Yrs. Mos. ds.*Contributory
(Secondary)(Duration) *Yrs. Mos. ds.*(Signed) *H.B. Pugh* M. D.*Jan 31 1924* (Address) *Reynolds*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Reynolds

DATE OF BURIAL

7/1 1924

20. UNDERTAKER

W. W. W.

ADDRESS

W. W. W.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

751 114 036 551
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Caribou

City of Malad

No. _____ St. _____

Hospital _____

FEB 4 1924
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. 26

File No. 119028

Primary Registration District No. 2869

Registered No. 5

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and _____	Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>1-14</u> 192 <u>4</u> (Month) (Day) (Year)
--------------------------	---	-----------	--------------------------------	------------------------	--

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth... 9 Number of child of this mother now living, including present birth... 6

FATHER
FULL NAME Mr. Kennedy
RESIDENCE Malad Ida
COLOR white AGE AT LAST BIRTHDAY 43
(Years)
BIRTHPLACE Malad Ida
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Miss Evans
RESIDENCE Malad
COLOR white AGE AT LAST BIRTHDAY 40
(Years)
BIRTHPLACE Malad Ida
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

Thos. J. M. Carson at 4:00 P. M.
(Born alive or stillborn)
M. W.
(Physician or midwife)

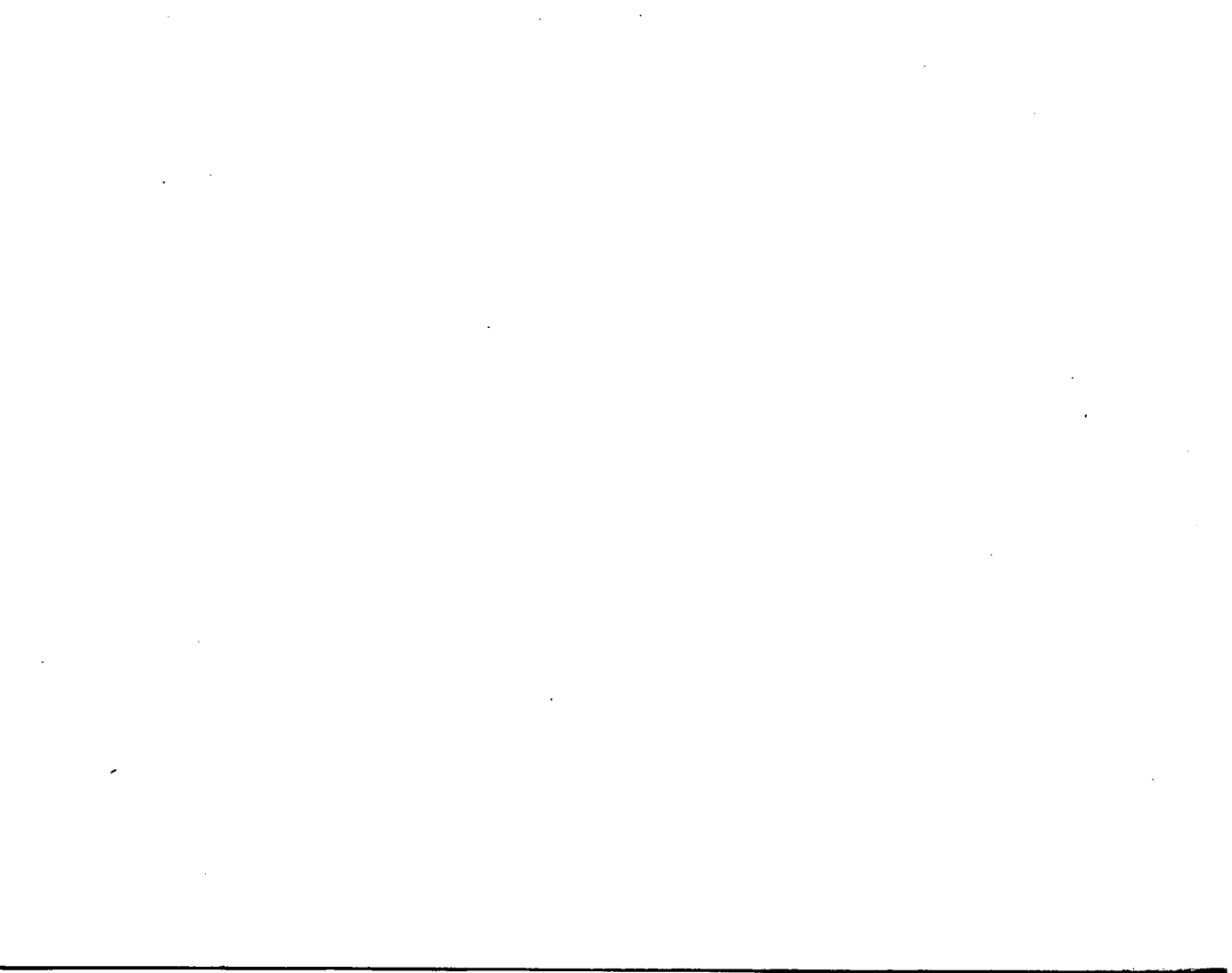
Give names added from a supplemental report.

Address

Filed

Malad Ida
1/31 1924 J. M. Carson
Registrar.

Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. R.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
218127 003855
County of Bannock
City of Dawney
No. St. Registration District No. 83 State File No.
Hospital Primary Registration District No. 3160 Local Registrar's No.
FULL NAME OF CHILD Unnamed

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH 119271

(Certificate of no value without full name of child.)
Sex of Child Male Twin Triplet or other? and Number in order of birth 1 Legitimate? Yes Date of birth 2-27-1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 2

FATHER		MOTHER	
FULL NAME	<u>John Ray</u>	FULL MAIDEN NAME	<u>Mona Bendicks</u>
RESIDENCE	<u>Swan Lake, Ida.</u>	RESIDENCE	<u>Swan Lake, Ida.</u>
COLOR	<u>White</u>	COLOR	<u>W</u>
AGE AT LAST BIRTHDAY	<u>28</u> (Years)	AGE AT LAST BIRTHDAY	<u>28</u> (Years)
BIRTHPLACE	<u>Swan Lake, Ida.</u>	BIRTHPLACE	<u>Richmond, Utah</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 145 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return.
A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) A. H. Hocking, M.D.
Physician
(Physician or midwife)

Give names added from a supplemental report.
....., 192.....

Address Dawney, Idaho
Filed 2-27-1924
Registrar.

Registrar.

THIS CERTIFICATE IS VALID ONLY WHEN THE FATHER'S NAME IS ENTERED IN THE SPACE PROVIDED THEREFOR. IF THE FATHER'S NAME IS NOT ENTERED, THE CERTIFICATE IS VOID.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

119571

No. _____ City of _____ County of _____
 Primary Registration District No. _____ Local Registrar's No. _____
 Registration District No. _____ State File No. _____

NAME OF CHILD

(Certificate is no value without full name of child)

Child _____ Sex of _____
 (To be answered only in event of birth) Number _____
 and in order of birth _____
 Date of birth _____
 (Month) _____ (Day) _____ (Year) _____

What supplemental notation was used in case?

FATHER		MOTHER	
NAME	RESIDENCE	NAME	RESIDENCE
FULL NAME	FULL NAME	FULL NAME	FULL NAME
AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY
COLOR	COLOR	COLOR	COLOR
BIRTHPLACE	BIRTHPLACE	BIRTHPLACE	BIRTHPLACE
OCCUPATION	OCCUPATION	OCCUPATION	OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
 on the date above stated.

When there was no attending physician or midwife, then the father, mother, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) _____
 (Physician or midwife)

Give names added from a supplemental report.
 Address _____
 Registrar _____
 Registrar _____

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

S

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

County of Bainrock

City of Pocatello

No. 391212003-415

St.

Registration District No. 28

State File No. 119322

Hospital Pres. Gen'l

Primary Registration District No. 2461

Local Registrar's No. 6298

FULL NAME OF CHILD Peggy Jean Trapp

(Certificate of no value without full name of child)

Sex of Child neither

Twin
Triplet
or other?

} and {

Number
in order
of birth

Legiti-
mate? yes

Date of
birth 7-17

(Month) (Day) (Year)

1924

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1

Number of child of this mother now living, including present birth 1

FULL
NAME

FATHER

Manning Allen Trapp

RESIDENCE

Pocatello Idaho

COLOR

wh

AGE AT LAST

BIRTHDAY 37

(Years)

BIRTHPLACE

Idaho

OCCUPATION

clerk

FULL
MAIDEN
NAME

MOTHER

Jesse Belle Davis

RESIDENCE

same

COLOR

wh

AGE AT LAST

BIRTHDAY 32

(Years)

BIRTHPLACE

Missouri

OCCUPATION

prof

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive 5:30 a. m.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) J. E. Ray

(Physician or midwife)

Address Pocatello Idaho

Filed 8/1

1924

Registrar.

Registrar.

DEC 10 1947

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

1. PLACE OF DEATH

County of *Barnock*
City of *POCATELLO, IDAHO*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Peggy Jean Trapp

CERTIFICATE OF DEATH

Registration District No. *28*

Primary Registration District No. *241*

General Hospital

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *44617*

Local Registrar's No. *4262*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

6. DATE OF BIRTH

Feb 12 1924
(Month) (Day) (Year)

7. AGE

Still born

IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Pocatello, Idaho

10. NAME OF

Father

Allen Trapp

11. BIRTHPLACE

OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME

OF MOTHER

Jessie Deuis

13. BIRTHPLACE

OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jessie D. Trapp

(Address)

Pocatello, Idaho

15.

Filed

Feb 27 1924

W. H. H. H.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 12 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *2-12 1924* to *2-12 1924*

that I last saw her alive on *2-12 1924*

and that death occurred on the date stated above, at *N.*

The CAUSE OF DEATH* was as follows:

Still birth. Died in utero 48 hours before birth.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

DeRay

M. D.

2-7-1924 (Address) *Pocatello*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death *Pocatello*
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

McLean

Feb 28 1924

20. UNDERTAKER

ADDRESS

McLEAN UNDERTAKING CO. POCATELLO, IDAHO

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

168 229 003-493
PLACE OF BIRTH

County of Bannock

City of Pocatello

No. 559 209th

RECEIVED
MAR 10 1924

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

BUREAU OF VITAL STATISTICS

Registration District No. 18

State File No. 119337

Hospital

Primary Registration District No. 2161

Local Registrar's No. 6314

FULL NAME OF CHILD

Will Born

(Certificate of no value without full name of child)

Sex of Child

F

Twin
Triplet
or other?

1

and

Number
in order
of birth

1

Legiti-
mate?

Yes

Date of
birth

Feb. 29 1924

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1

Number of child of this mother now living, including present birth 0

FATHER
FULL NAME
Everitt Somerville Johnston

RESIDENCE
559 209th

COLOR
White

AGE AT LAST
BIRTHDAY 32
(Years)

BIRTHPLACE
Newburgh N. Y.

OCCUPATION
Grain Business

MOTHER
FULL MAIDEN NAME
Helen Milson

RESIDENCE
559 209th

COLOR
White

AGE AT LAST
BIRTHDAY 30
(Years)

BIRTHPLACE
Catasagua, Penna.

OCCUPATION
Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 9³⁰ a. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

H. E. Howard M.D.
(Physician or midwife)

Address

Pocatello Idaho

Filed

2/1 1924

J. Young
Registrar.

Registrar.

1. If in case of death, the child is still alive, the mother must be notified to the hospital to which the child was taken to die.
 2. If the child is still alive, the mother must be notified to the hospital to which the child was taken to die.
 3. If the child is still alive, the mother must be notified to the hospital to which the child was taken to die.

(Give names added from a supplemental report.)
 child is one that neither prescribes nor
 etc. should not be returned. A stillborn
 or motherless than the father, household
 *When there was no attending physician
 on the date above stated.

I hereby certify that I attended the birth of this child, who was born on the date above stated.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

OCCUPATION

BIRTHPLACE

AGE AT LAST BIRTHDAY (Year)

COLOR

AGE AT LAST BIRTHDAY (Year)

BIRTHPLACE

RESIDENCE

FULL MAIDEN NAME

MOTHER

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

SEX

Twin
Triplet
or other

Number of child of this mother

Weight
Males

Date of birth

(Day)

(Year)

ACTUAL NAME OF CHILD

Certificate of birth of child

Hospital District No.

Registration District No.

CERTIFICATE OF BIRTH

DEPARTMENT OF PUBLIC WELFARE

STATE OF IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

1. PLACE OF DEATH

County of Barnack
City of Pocostello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Johnston

CERTIFICATE OF DEATH

Registration District No. 28
Primary Registration District No. 2161
No. 1559 So. 9th street

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 44620
Local Registrar's No. 4265

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single

6. DATE OF BIRTH Feb 29 1924
(Month) (Day) (Year)

7. AGE Still born IF LESS than 1 day how many hrs. or min.?
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work none
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Pocostello, Idaho

10. NAME OF Father E. Sommerwill Johnston

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Helen Mitson

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. Sommerwill Johnston
(Address) Pocostello, Idaho

15. Filed Feb 29 1924
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 29 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from Feb. 29 1924 to Feb. 29 1924
that I last saw him alive on Still born
and that death occurred on the date stated above, at 9:30 A.M.
The CAUSE OF DEATH* was as follows:
Stillborn (asphyxia)

(Duration) yrs. mos. ds.
Contributory (Secondary) Still born
(Duration) yrs. mos. ds.
(Signed) W. F. Howard M. D.
(Address) Pocostello, Idaho

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Mt Union Cem. Pocostello DATE OF BURIAL Mar 1924

20. UNDERTAKER McHardy & Co. ADDRESS Pocostello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

385 218003-744

RECEIVED
MAY 1 1924

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock

City of Ten Mile Bancroft

CERTIFICATE OF BIRTH

119360

No. _____ St. _____

Registration District No. 84

File No. _____

Hospital _____

Primary Registration District No. 2161

Registered No. 43

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Baby Bennett

Sex of Child

Female

Twin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

Yes

Date of
birth

2 - 18 - 1924
(Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth... 9

Number of child of this mother now living, including present birth... 9

FULL
NAME

FATHER
John D. Bennett

FULL
MAIDEN
NAME

MOTHER
Nettie Gummarsall

RESIDENCE

Ten Mile Bancroft

RESIDENCE

Ten Mile Bancroft

COLOR

White

AGE AT LAST
BIRTHDAY

47
(Years)

COLOR

White

AGE AT LAST
BIRTHDAY

39
(Years)

BIRTHPLACE

France

BIRTHPLACE

England

OCCUPATION

Farmer

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn, at 1 A.M.
on the date above stated. (Born alive or stillborn)

* When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

Physician
(Physician or midwife)

Give names added from a supplemental report.

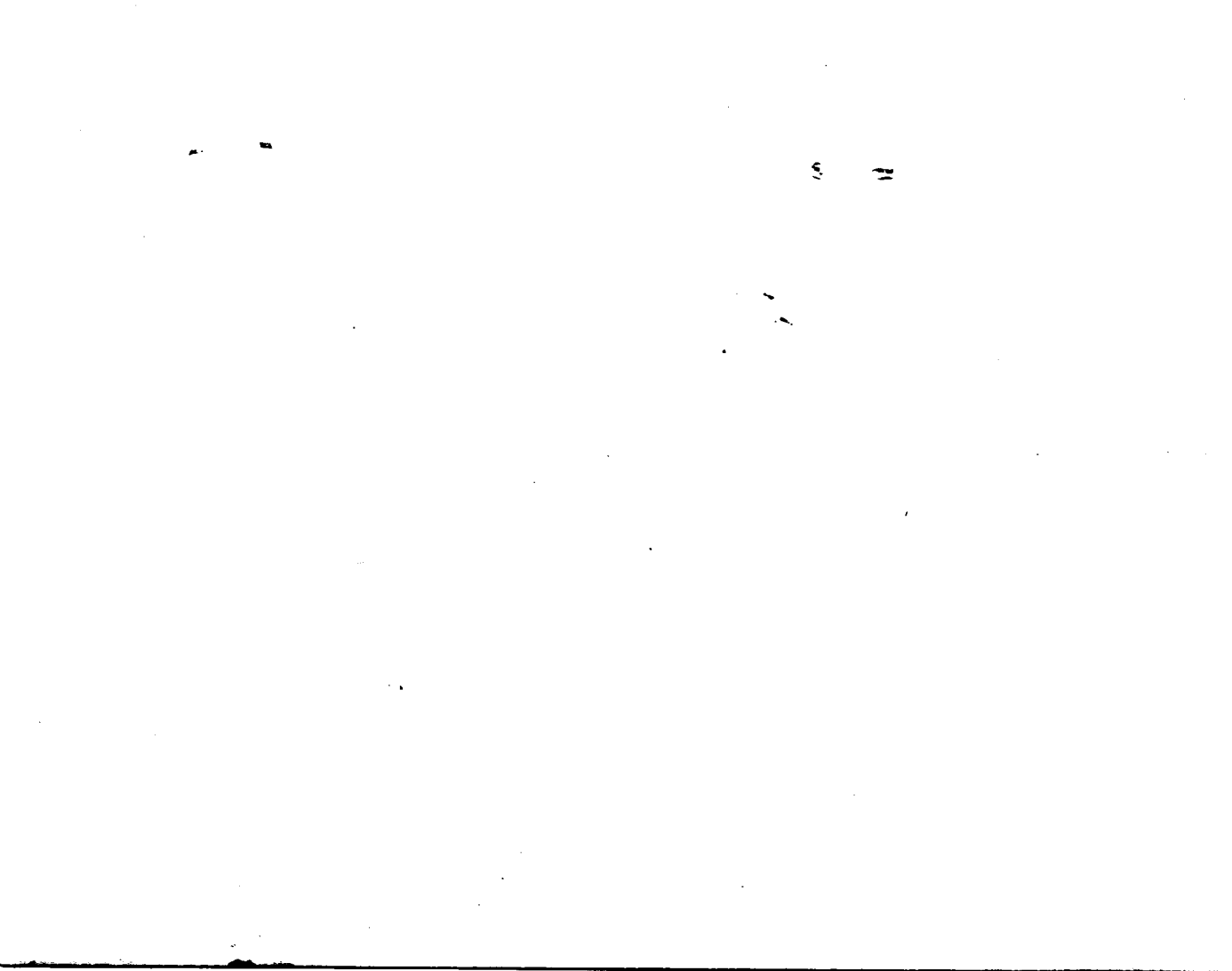
Address

Bancroft Idaho

Filed Mar - 1 - 1924

Mrs. J. J. Felt
Registrar.

Registrar.



1. PLACE OF DEATH

County of Bannock
 City of Ten Mile Bannock

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn

RECEIVED CERTIFICATE OF DEATH

Registration District No. 84
 Primary Registration District No. 2161
 STATE OF IDAHO

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 44623
 Registered No. 12

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

2 — 18 — 1924
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

John D. Churcett

11. BIRTHPLACE OF FATHER

(State or Country)

France

12. MAIDEN NAME OF MOTHER

Nettie Gunnison

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Mar-1 1924

Mrs. J. G. Fitz
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2 — 18 — 1924
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Unknown. Stillborn.

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed) B. B. H. M. D.

2-18-1924 (Address) Bancroft

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

Had none

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH *Bonanza Idaho Falls*
 County of *Jefferson*
 City of *Rexburg*
 No. *Rexburg Pte 2* St. *104010-314*
 Hospital *685-104010-314*
 FULL NAME OF CHILD *Wheeler*

STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS
 RECEIVED
 MAR 15 1924
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH
 Registration District No. *73* State File No. *11952*
 Primary Registration District No. *2147* Local Registrar's No. *47*

(Certificate of no value without full name of child)

Sex of Child *Male* Twin Triplet or other? ** and { Number in order of birth ** Legitimate? *Yes* Date of birth *Feb 4 1924*
 (To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? *Silver*

Number of child of this mother, including present birth _____ Number of child of this mother now living, including present birth _____

FATHER		MOTHER	
FULL NAME	<i>Fred Wheeler</i>	FULL MAIDEN NAME	<i>Joan Cameron</i>
RESIDENCE	<i>Rexburg - Pte 2</i>	RESIDENCE	<i>Same</i>
COLOR	<i>white</i>	COLOR	<i>white</i>
AGE AT LAST BIRTHDAY (Years)		AGE AT LAST BIRTHDAY (Years)	<i>36</i>
BIRTHPLACE		BIRTHPLACE	
OCCUPATION	<i>Farmer</i>	OCCUPATION	<i>Housewife</i>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was *(Born alive)* *Stillborn* at *5:45 a* M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) *[Signature]*

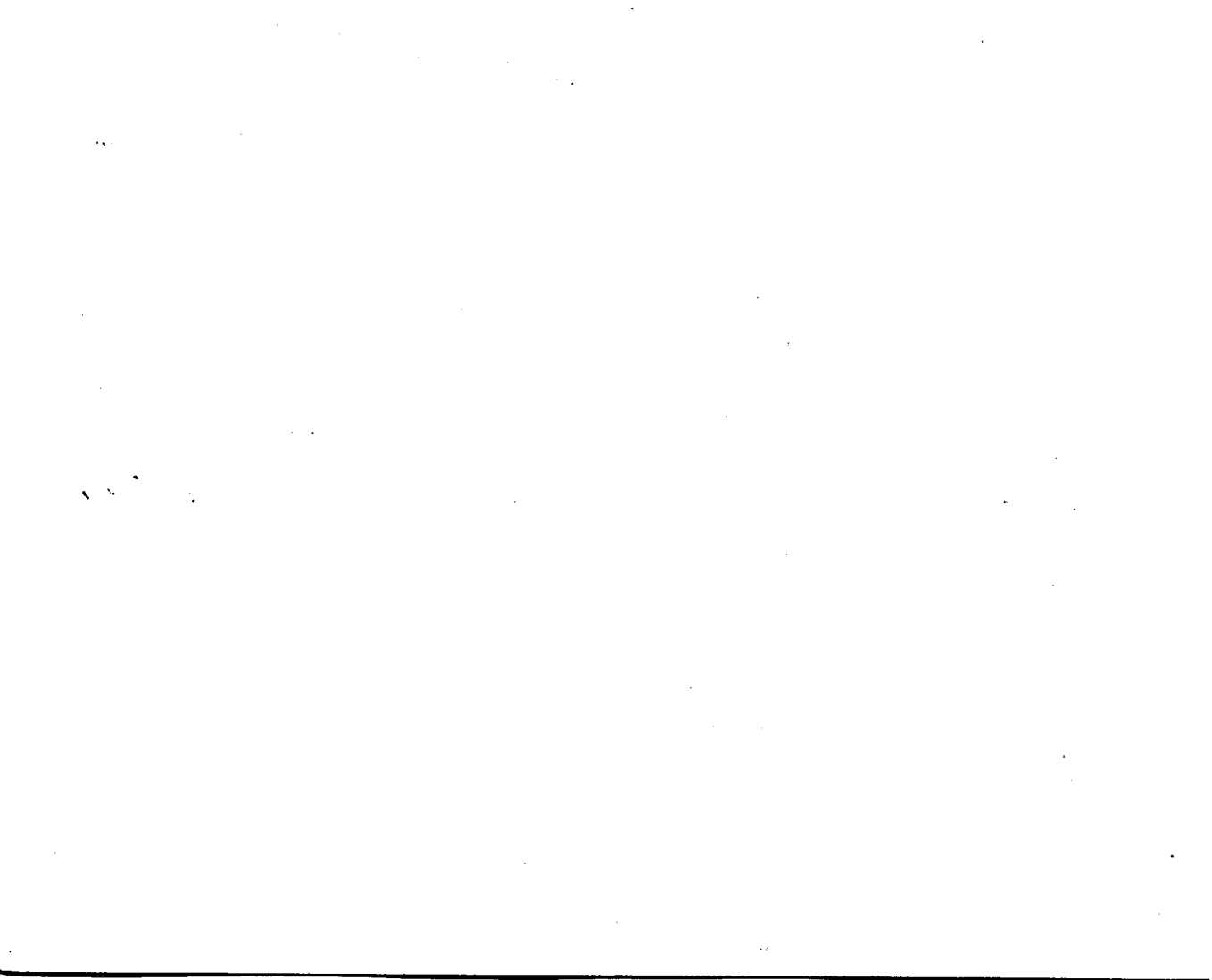
(Physician or midwife)

Address *Idaho Falls, Ida*

Filed *Feb 4* 192 *4* Registrar.

Registrar.

Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

386 112-016-764
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Cassia

City of Burley

No. _____

Hospital _____

FULL NAME OF CHILD Baby

RECEIVED

MAR 10 1924

Registration District No. 117

Primary Registration District No. 2196

CERTIFICATE OF BIRTH

File No. 119650

Registered No. 2769

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>None</u>	and {	Number in order of birth <u>3</u>	Legitimate? <u>Yes</u>	Date of birth <u>2-19</u> 192 <u>4</u> (Month) (Day) (Year)
--------------------------	------------------------------------	-------	-----------------------------------	------------------------	--

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4

FATHER
FULL NAME Henry Thompson
RESIDENCE Burley

COLOR White AGE AT LAST BIRTHDAY 33
(Years)

BIRTHPLACE Colo.

OCCUPATION Farming

MOTHER
FULL MAIDEN NAME Luah Corlton
RESIDENCE Burley

COLOR White AGE AT LAST BIRTHDAY 28
(Years)

BIRTHPLACE Ida

OCCUPATION Mother

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born dead at 3 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) L. H. Butler
M.D.
(Physician or midwife)

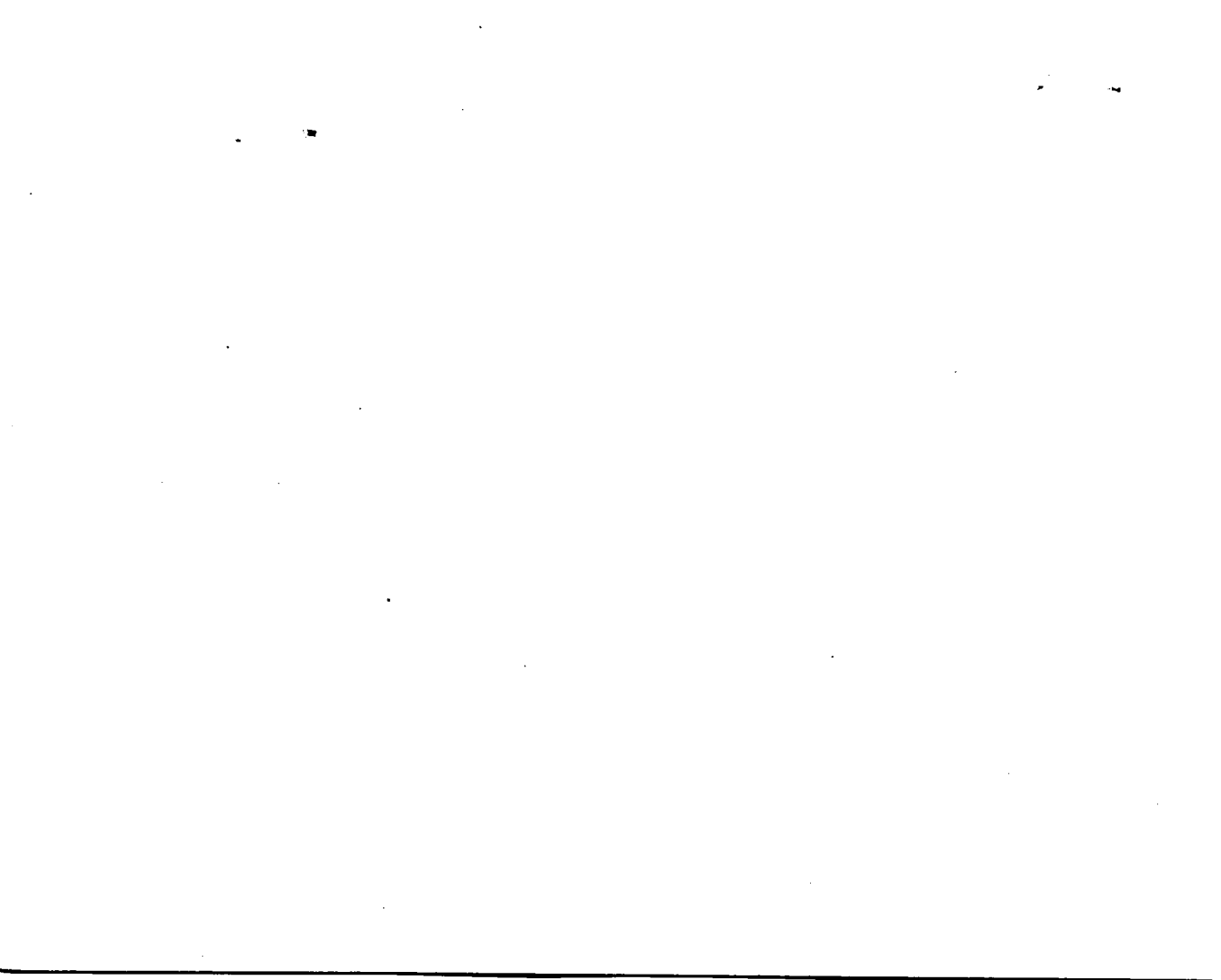
Give names added from a supplemental report.

Address Burley Ida

Filed 3-6 1924 H. J. C. Patterson

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

Cutler
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *44730*
Registered No. *694*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of *Cassia*
City of *Burley*

Registration District No. *117*

Primary Registration District No. *2196*

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Thompson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Feb. *12* *1924*
(Month) (Day) (Year)

7. AGE

Still Born

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Burley, Idaho

10. NAME OF FATHER

John Henry Thompson

11. BIRTHPLACE OF FATHER

(State or Country)

Colorado

12. MAIDEN NAME OF MOTHER

Sarah Poulton

13. BIRTHPLACE OF MOTHER

(State or Country)

Oakley, Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. H. Thompson*

(Address) *Burley, Ida.*

15.

Filed *2-13* *1924* *R. J. Callahan*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. *12* *1924*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 12 *1924* to *Feb 12* *1924*

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Pressing on cord prior to labor

(Duration)..... Yrs..... mos..... ds.

Contributory
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)

F. H. Cutler

M. D.

213 *1924*

(Address) *Burley*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley, Ida.

DATE OF BURIAL

Feb. 13 *1924*

20. UNDERTAKER

L. B. Galloway

ADDRESS

Burley, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Madison **RECEIVED**
City of Reising **MAR 7 1924**
No. 291-210033-291 **BUREAU OF VITAL STATISTICS** **CERTIFICATE OF BIRTH** **119792**
St. Reising General Registration District No. 100 State File No. 119792
Hospital Reising General Primary Registration District No. 2128 Local Registrar's No. 710
FULL NAME OF CHILD.....

(Certificate of no value without full name of child)

Sex of Child Female { Twin Triplet or other? } and { Number in order of birth } Legiti- mate? Yes Date of birth Feb 10 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? 15% Argysol

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME L. R. Mc Bratney
RESIDENCE St Anthony
COLOR W AGE AT LAST BIRTHDAY 26 (Years)
BIRTHPLACE Ill.
OCCUPATION State Employee

MOTHER
FULL MAIDEN NAME Jessie Bray
RESIDENCE St. Anthony
COLOR W AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Nebraska
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn { Stillborn } at Feb. 10, 200 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) H. B. Ryby

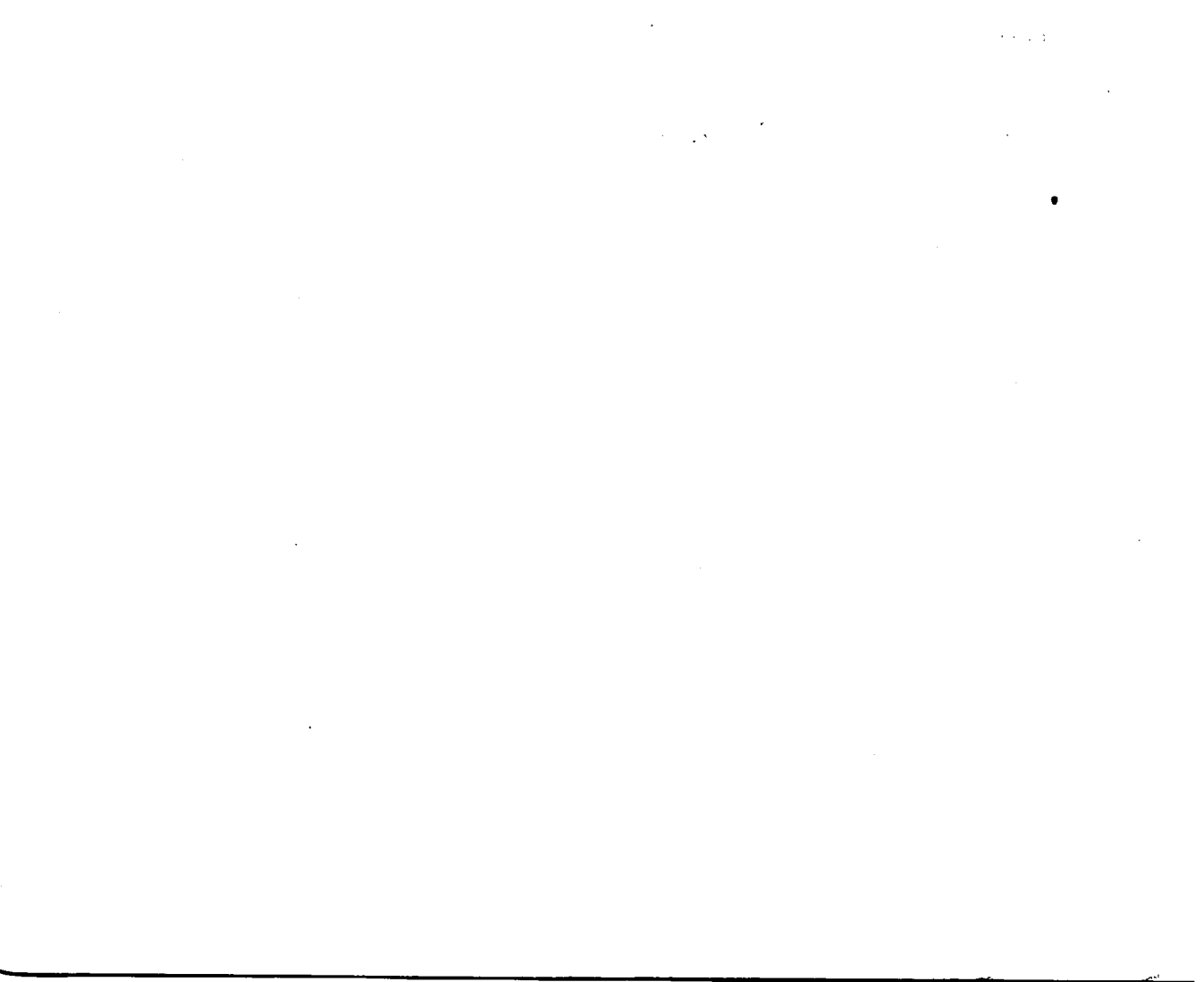
(Physician or midwife)

Address

Filed 2/1 1924 May 7

Registrar.

Registrar.



PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of SanidaCity of MaladNo. 993-115-036-165 St.Registration District No. 26State File No. 119877

Hospital

Primary Registration District No. 2069Local Registrar's No. 25

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

MaleTwin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legitimate

Yes

Date of birth

2-15-1924

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

1% silver

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FULL NAME

Wm. Hill

FATHER

FULL MAIDEN NAME

Phoebe Jones

MOTHER

RESIDENCE

Malad Id.

RESIDENCE

Malad Id.

COLOR

white

AGE AT LAST BIRTHDAY

49

(Years)

COLOR

white

AGE AT LAST BIRTHDAY

45

(Years)

BIRTHPLACE

Malad Id.

BIRTHPLACE

Malad Id.

OCCUPATION

Farmers

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 12:15 a M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

(Signature)

J. M. Harris
M.D.

(Physician or midwife)

Address

Malad Id.

Filed

3/1

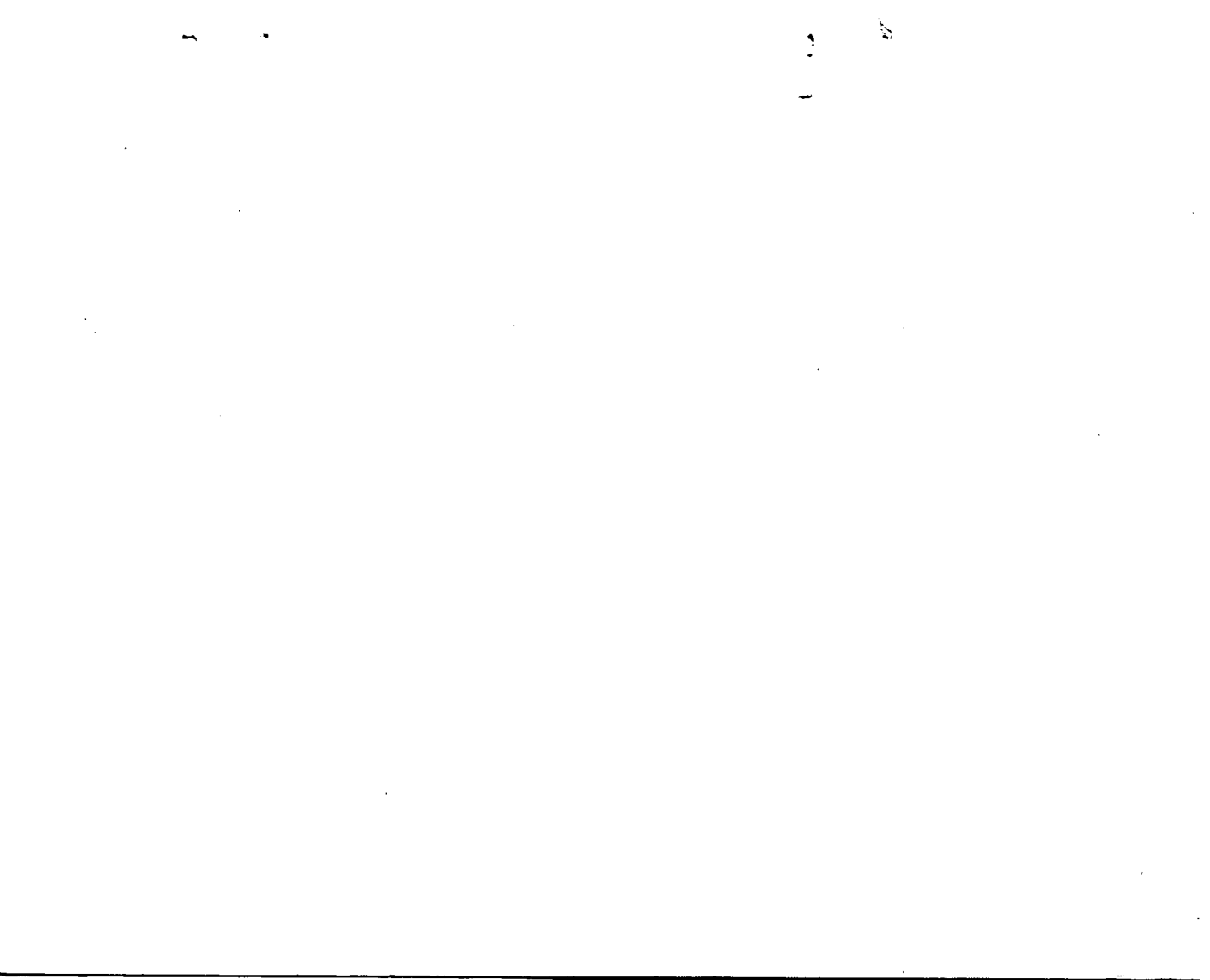
192

J. M. Harris

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



FORM V-S. No. 25 M. 1-19.

1. PLACE OF DEATH

County of Quincy Registration District No. 2069
 City of Mulat Primary Registration District No. 2069 St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Not Named.

RECEIVED
 MAR 8 1924
 BUREAU OF VITAL STATISTICS

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 44546
 Registered No. 6

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male White Infant
 (Write the word.)

6. DATE OF BIRTH

2-15-24
 (Month) (Day) (Year)

7. AGE

Stillborn
 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Mulat Id

10. NAME OF FATHER

Wm Hill

11. BIRTHPLACE OF FATHER

(State or Country) Id

12. MAIDEN NAME OF MOTHER

Phoebe James

13. BIRTHPLACE OF MOTHER

(State or Country) Id

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. J. M. Thomas

(Address) Mulat Id

15. 2/15-24 J. M. Thomas
 Filed 19 24 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2-15-24
 (Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from my attendance
 19 to 19

that I last saw h. alive on 19 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn
7 mos. unknown

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Thomas M. D.

2/15-24 (Address) Mulat Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mulat Id 2/15-24

20. UNDERTAKER ADDRESS

Parents Mulat Id

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL. or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

258.717014 433
PLACE OF BIRTH

Form V. S. No. 11--20m-7-26-19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF ~~Vital~~ STATISTICS
CERTIFICATE OF BIRTHS
119891

County of Canyon

City of Nampa

No. St.

Registration District No. 7

File No.

Hospital

Primary Registration District No. 1006

Registered No.

FULL NAME OF CHILD

"Infant"

Snyder

Sex of Child Male
Twin
Triplet
or other? } and { Number
in order
of birth
(To be answered only in event of plural births)

Legitimate? Yes

Date of Birth Feb 17th 24
(Month) (Day) (Year)FULL NAME FATHER
Ross E. SnyderFULL MAIDEN NAME MOTHER
Margarett McConnell

RESIDENCE Nampa - Idaho

RESIDENCE Nampa - Idaho

COLOR White AGE AT LAST BIRTHDAY 27
(Years)COLOR White AGE AT LAST BIRTHDAY 26
(Years)

BIRTHPLACE Kansas

BIRTHPLACE Kansas

OCCUPATION Postman
WHAT BACTERIOLOGICAL EXAMINATION WAS USED IN EYES?

OCCUPATION Housewife

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was
on the date above stated.Stillborn at 11:45
(Born alive or stillborn)*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

Physician

(Physician or midwife)

Given names added from a supplemental report.

19

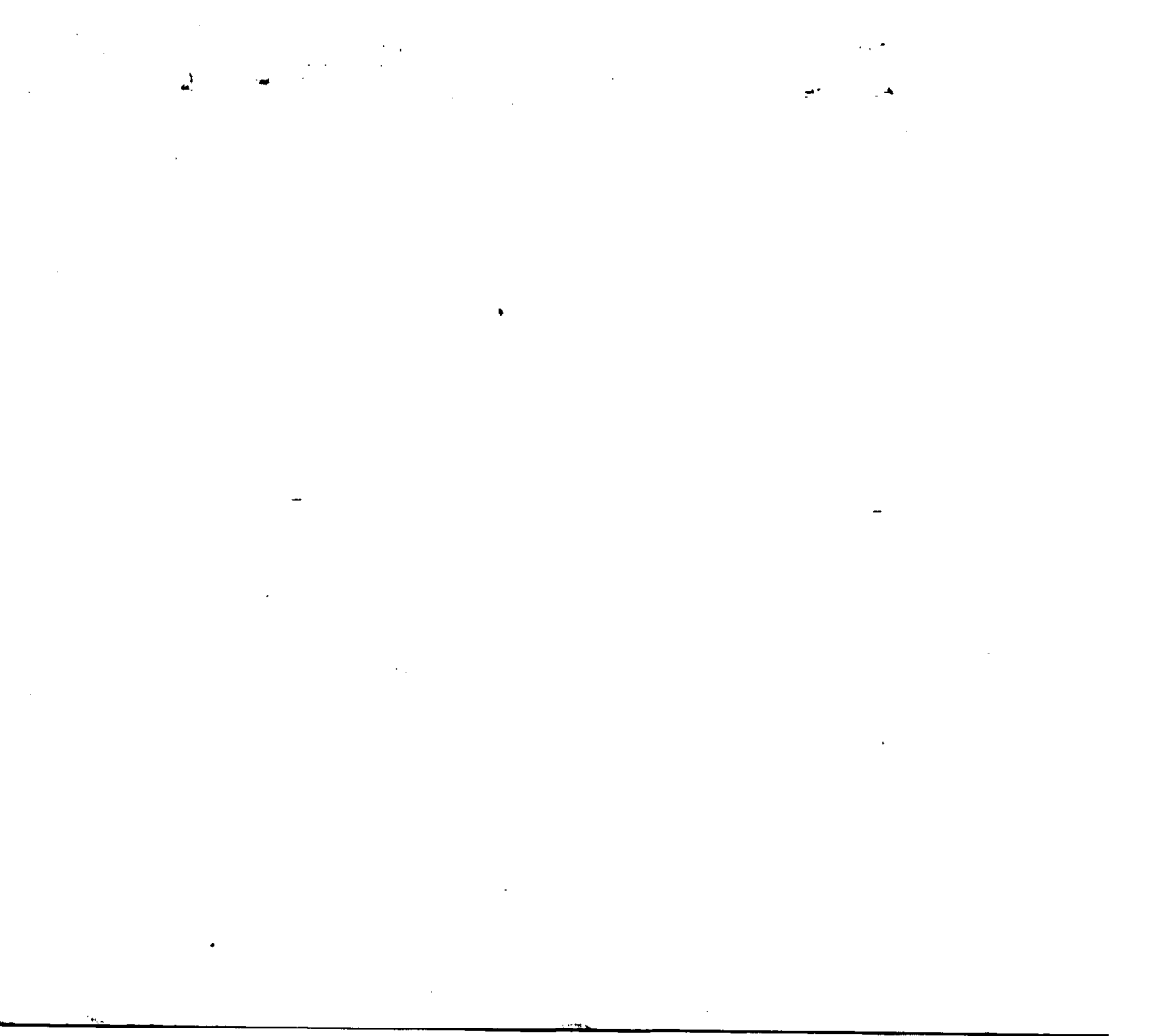
Address

Filed

Mar. 2 1924 Pearl Dodd

Registrar.

Registrar.



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County Blaine
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. St.)

State File No. 44698
Local Registrar's No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Son of R. E. Snyder

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

Feb 17 1924
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
hrs. or min.?

1 Yrs. 2 Mos. 2 ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF Father

Ross E. Snyder

11. BIRTHPLACE OF FATHER

(State or Country) Kansas

12. MAIDEN NAME OF MOTHER

Margaret M. Connell

13. BIRTHPLACE OF MOTHER

(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ross E. Snyder

(Address)

Nampa, Idaho

15.

Filed Mar. 3 1924 Leah Dodds

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 17 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19

that I last saw him alive on 19, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Still-born

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

John E. Mangum M. D.

3-1-1924 (Address)

Nampa, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury, and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlerman Ave

Feb 19 1924

20. UNDERTAKER

ADDRESS

J. T. Robinson

Nampa, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)**. For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.**, **Carcinoma, Carcoma, etc.**, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train**—**accident**; **Revolver wound of head**—**homicide**; **Poisoned by carbolic acid**—**probably suicide**. The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

Man

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

MAR 11 1924

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of *Twin Falls*

City of *File*

No. *498 243042866* St.

Registration District No.

38

File No. *119952*

Hospital

Primary Registration District No.

2086

Registered No.

FULL NAME OF CHILD

Not Named

(Certificate of no value without full name of child)

Sex of Child

M

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

Yes

Month

13

4

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

none

Number of child of this mother, including present birth

7

Number of child of this mother now living, including present birth

6

FULL
NAME

FATHER

Chas Snyder

FULL
MAIDEN
NAME

MOTHER

Bertha Howard

RESIDENCE

File Ida

RESIDENCE

File Ida

COLOR

W

AGE AT LAST
BIRTHDAY

48

(Years)

COLOR

W

AGE AT LAST
BIRTHDAY

40

(Years)

BIRTHPLACE

Ida

BIRTHPLACE

Ida

OCCUPATION

Farmer

OCCUPATION

Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.

(Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

Dr A A Newberry
(Physician or midwife)

Give names added from a supplemental report.

Address

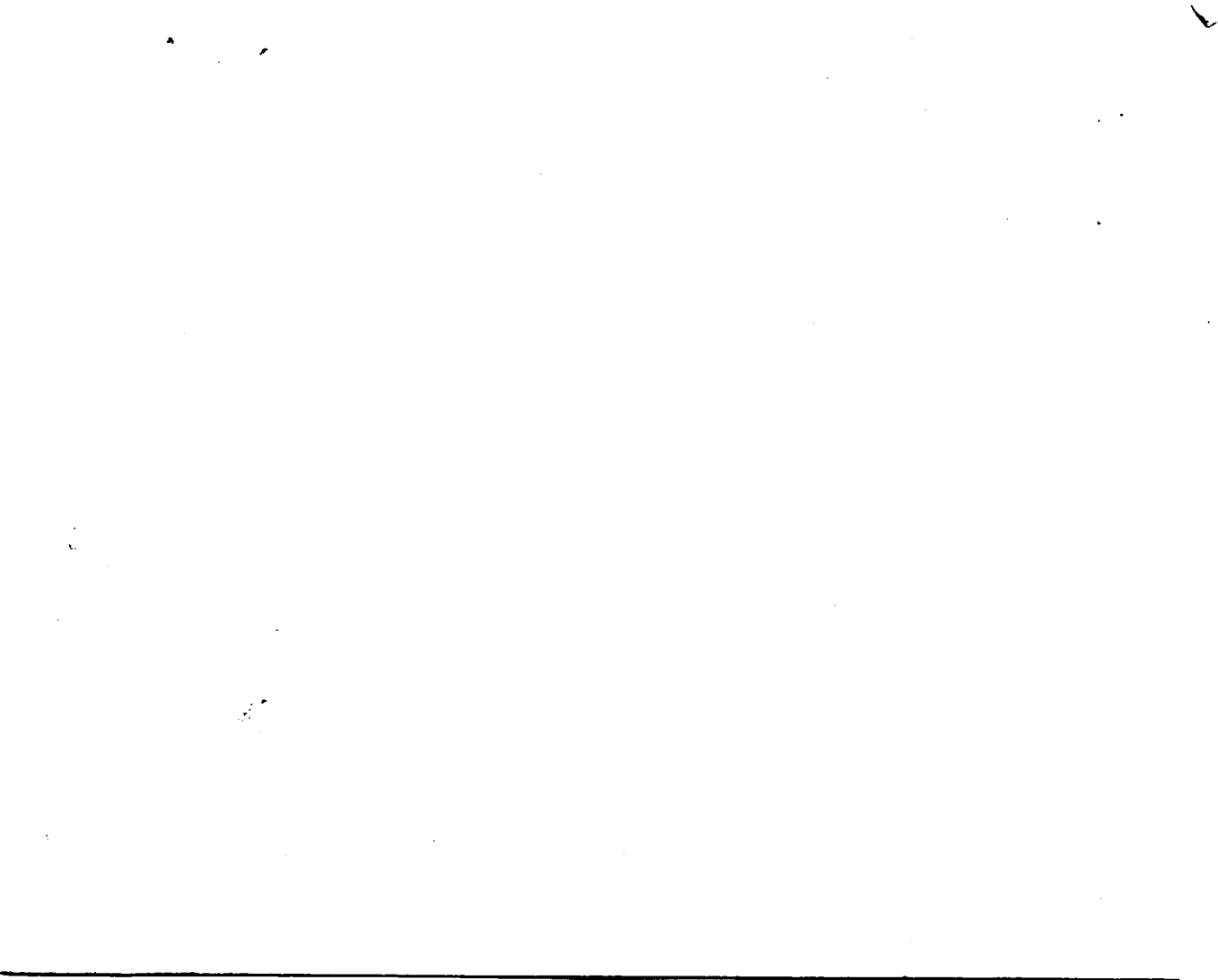
Filed

13

1924

Registrar.

Registrar.



PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

RECEIVED

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

119975

County of Valley
City of 3 1/2 miles northwest of
Nowood, Idaho
No. 415-216043-988 St. Registration District No. 15 State File No. 119975
Hospital _____ Primary Registration District No. _____ Local Registrar's No. _____
FULL NAME OF CHILD none - Stillbirth (about 8 1/2 months)
(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? yes Date of birth Jan 16 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME

John Maempaa

RESIDENCE

Nowood Idaho

COLOR

white

AGE AT LAST BIRTHDAY

29
(Years)

BIRTHPLACE

Wyoming.

OCCUPATION

Labour

MOTHER
FULL MAIDEN NAME

Martha Pyzsko

RESIDENCE

Nowood Idaho

COLOR

white

AGE AT LAST BIRTHDAY

26
(Years)

BIRTHPLACE

Finland

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 1:00 a. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

J. F. Rutledge, M.D.

(Physician or midwife)

Address

Cascade, Idaho

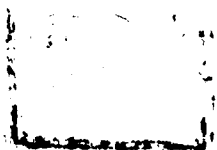
Filed

Feb 1

1924

Stella Cain
D. J. D. J. Registrar.

Registrar.



1900

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED

Registration District No. 15

County of

Valley

Primary Registration District No.

City of

Nowood (3 1/2 miles northwest)

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillbirth

File No.

1-1-01

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female

white

Single

(Write the word.)

6. DATE OF BIRTH

Jan

16

1924

(Month)

(Day)

(Year)

7. AGE

8 1/2 months in utero

Yrs. Mos. ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

Idaho

(State or Country)

10. NAME OF FATHER

John Maempaa

11. BIRTHPLACE OF FATHER

Wyoming

(State or Country)

12. MAIDEN NAME OF MOTHER

Martha Pyykko

13. BIRTHPLACE OF MOTHER

Finland

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Maempaa

(Address)

Nowood Ida

15.

Filed

19

Local Registrar

Stillbirth
W. J. Ruttledge

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan

16

1924

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 16

1924

to

Jan 16

1924

that I last saw him alive on

19

and that death occurred on the date stated above, at 1:00 P.M.

The CAUSE OF DEATH* was as follows:

Stillbirth - Eclampsia of mother

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. F. Ruttledge M. D.

1-16 1924

(Address) Cascade Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

249-225 004-651

PLACE OF BIRTH

STATE OF IDAHO

Form V. S. No. 11-C-20m-2-15-12

BUREAU OF VITAL STATISTICS

RECEIVED

APR 8 1924

CERTIFICATE OF BIRTH

S 120084

County of Blaine LakeCity of BenningtonBUREAU OF VITAL
STATISTICS

File No. _____

No. _____ St. _____

Primary Registration District No. 2136

Registered No. _____

Hospital _____

FULL NAME OF CHILD

Hazel SmithSex of
ChildGirlTwin
Triplet
or other?

{

and

{

Number

in order

of birth

{

(To be answered only in event of plural births)

{

Legiti-

mate?

{

yes

{

Date of

Birth

{

2

{

6-

{

1924

{

(Month)

{

(Day)

{

(Year)

{

1924

{

(Year)

{

(Year)

{

(Year)

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(Year)

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(Year)

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(Year)

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(Year)

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(Year)

{

(Year)

{

(Year)

{

(Year)

FULL NAME

Louis L. Smith

FATHER

FULL MAIDEN NAME

Mary E. Weaver

MOTHER

RESIDENCE

Bennington

RESIDENCE

Bennington

COLOR

White

AGE AT LAST BIRTHDAY

31
(Years)

COLOR

White

AGE AT LAST BIRTHDAY

23
(Years)

BIRTHPLACE

Bennington

BIRTHPLACE

Bennington

OCCUPATION

Farmer

OCCUPATION

WifeNumber of child of this mother, including present birth 2Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 9 a M. on the date above stated.

(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Geo. F. Ashley M.D.

(Physician or midwife)

Given names added from a supplemental report

19

Address

Montpelier N.H.
4/15/24

Filed

19

Registrar

SHAW'S BOOKS & PAPERS

Boise, Idaho

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

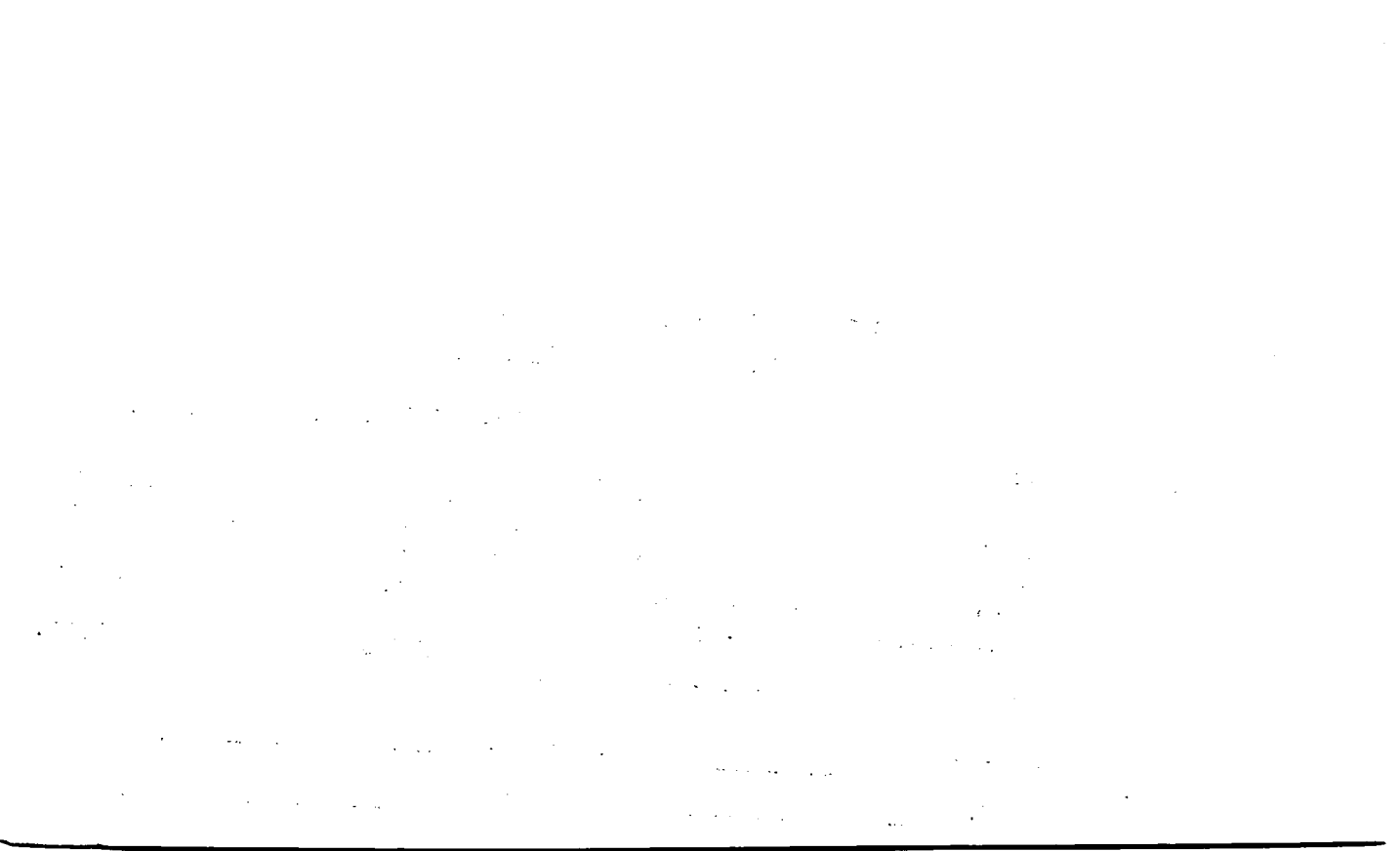
Place of Birth (CITY Georgetown FILE NO. 120084
(ST. Idaho DATE OF BIRTH Mar. 4 1924
(COUNTY Bear Lake SEX OF CHILD Female
FATHER Lewis L MOTHER Maitha Weaver
(MAIDEN NAME)

I HEREBY CERTIFY that the child herein described has been named:

Harold Smith

RECEIVED
JUN 12 1924
BUREAU OF VITAL

Mrs Lewis L Smith
Signature of Father or Mother.



WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. R.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO	
DEPARTMENT OF PUBLIC WELFARE		BUREAU OF VITAL STATISTICS	
County of <u>Bingham</u>	City of <u>Blackfoot</u>	BUREAU OF VITAL STATISTICS	
No. <u>664-208000-844</u>	St. <u>Blackfoot</u>	Registration District No. <u>121</u>	State File No. <u>120152</u>
Hospital	Primary Registration District No. <u>1007</u>	Local Registrar's No. <u>80</u>	
FULL NAME OF CHILD <u>No name Womack</u>			
(Certificate of no value without full name of child)			
Sex of Child <u>Female</u>	Twin <u>yes</u> and { Number in order of birth <u>1</u> } (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of birth <u>Mar 8</u> 192 <u>4</u> (Month) (Day) (Year)
What bactericidal solution was used in eyes? <u>—</u>			
Number of child of this mother, including present birth <u>4</u>		Number of child of this mother now living, including present birth <u>3</u>	
FATHER	MOTHER		
FULL NAME <u>Vern Frank Womack</u>	FULL MAIDEN NAME <u>Earl Humphreys</u>		
RESIDENCE <u>Blackfoot</u>	RESIDENCE <u>Blackfoot</u>		
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>27</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>24</u> (Years)		
BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Idaho</u>		
OCCUPATION <u>Farming</u>	OCCUPATION <u>Housewife</u>		
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.			
I hereby certify that I attended the birth of this child, who was <u>Stillborn</u> at <u>1:40 a</u> M. on the date above stated.			
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.			
Give names added from a supplemental report.			
, 192 <u>4</u>			
Address <u>Blackfoot, Idaho</u>		Filed <u>Mar 13</u> 192 <u>4</u>	
Registrar.		Registrar.	

4

Q

8 7 4 1 3

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho _____

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY _____
(ST. _____
(COUNTY _____

FILE NO. _____ 120152

DATE OF BIRTH _____

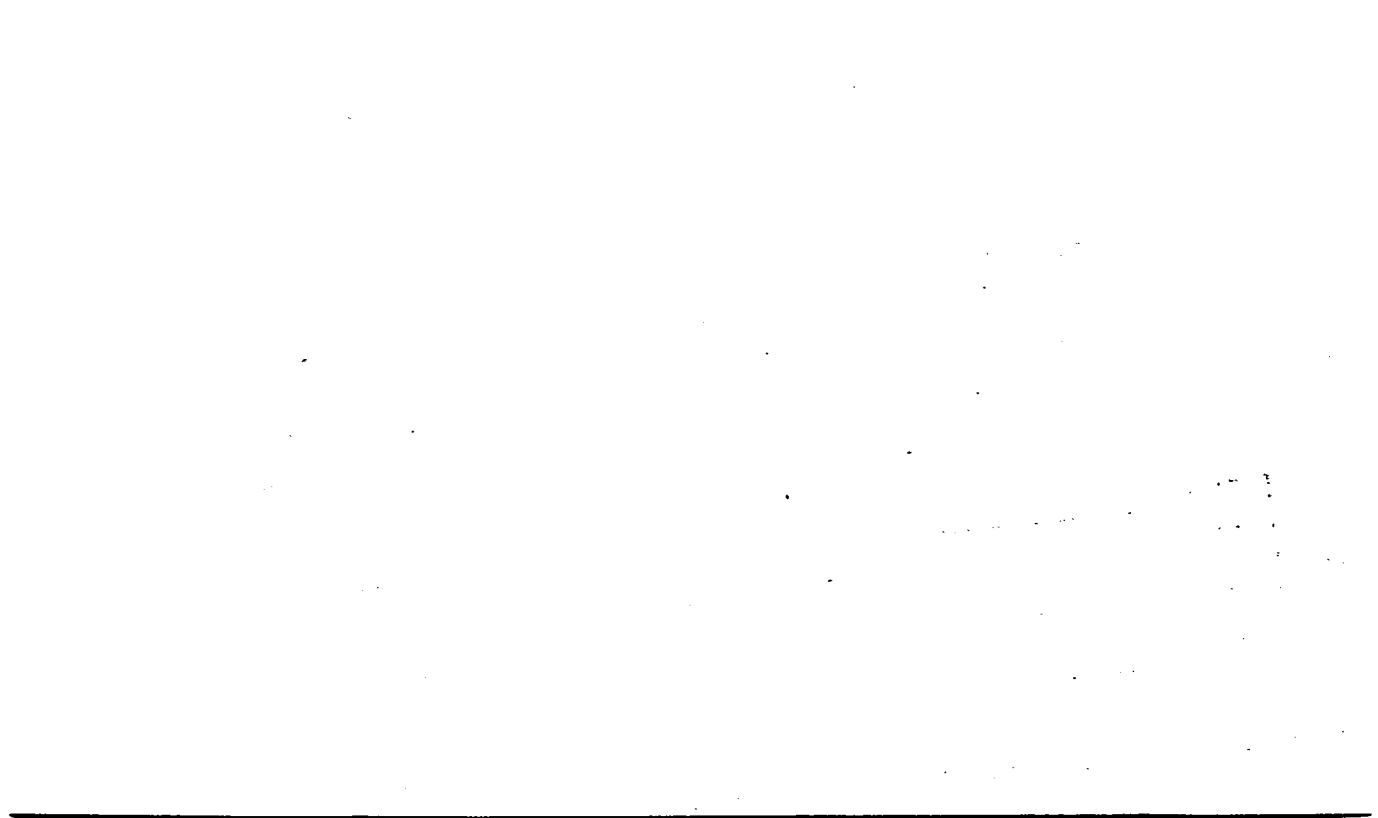
SEX OF CHILD _____ Female

FATHER _____

MOTHER _____

(MAIDEN NAME)

I HEREBY CERTIFY that the child herein described has been named:



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bingham Registration District No. 121
City of Blackfoot Primary Registration District No. 1007
(No. 20 Oak St St.)

File No. 44955
Registered No. 38

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

No Name Womack

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Female White Single
(Write the word.)

6. DATE OF BIRTH.

March 8 1924
(Month) (Day) (Year)

7. AGE

Stillborn ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Vern Frank Womack

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Pearl Humphreys

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Vern Frank Womack

(Address)

Blackfoot, Ida.

15.

Filed

Mar 8 1924M. C. Womack, Reg.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Stillborn 191.....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
..... 191..... to 191.....

that I last saw h..... alive on 191.....
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Was a twin stillborn and
had been dead at least
2 1/2 months. Other twin healthy
(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. W. Beck M. D.
3/8/24 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Interment place 5000 Clear Mar 8 1924

20. UNDERTAKER Womack ADDRESS

Vern Frank Womack

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 5 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

266-125 009 9/12

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonner

City of Sandpoint

No. _____ St. _____

Hospital City

Registration District No. 78

File No. _____

Primary Registration District No. 2155

Registered No. _____

CERTIFICATE OF BIRTH

120219

FULL NAME OF CHILD still born

(Certificate of no value without full name of child.)

Sex of
Child male

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

3/25/24

192

(Month)

(Day)

(Year)

(To be answered only in event of plural births)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 3

Number of child of this mother now living, including present birth 2

FULL
NAME

FATHER

Dewey Bowker

RESIDENCE

Sandpoint Idaho

COLOR

white

AGE AT LAST

BIRTHDAY

(Years)

BIRTHPLACE

Ohio

OCCUPATION

laborer

FULL
MAIDEN
NAME

MOTHER

Agnes Esther Rasmussen

RESIDENCE

Sandpoint Idaho

COLOR

white

AGE AT LAST

BIRTHDAY

23

(Years)

BIRTHPLACE

Minn

OCCUPATION

housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 12:30 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

M. D. Wallentin

M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address

Sandpoint Idaho.

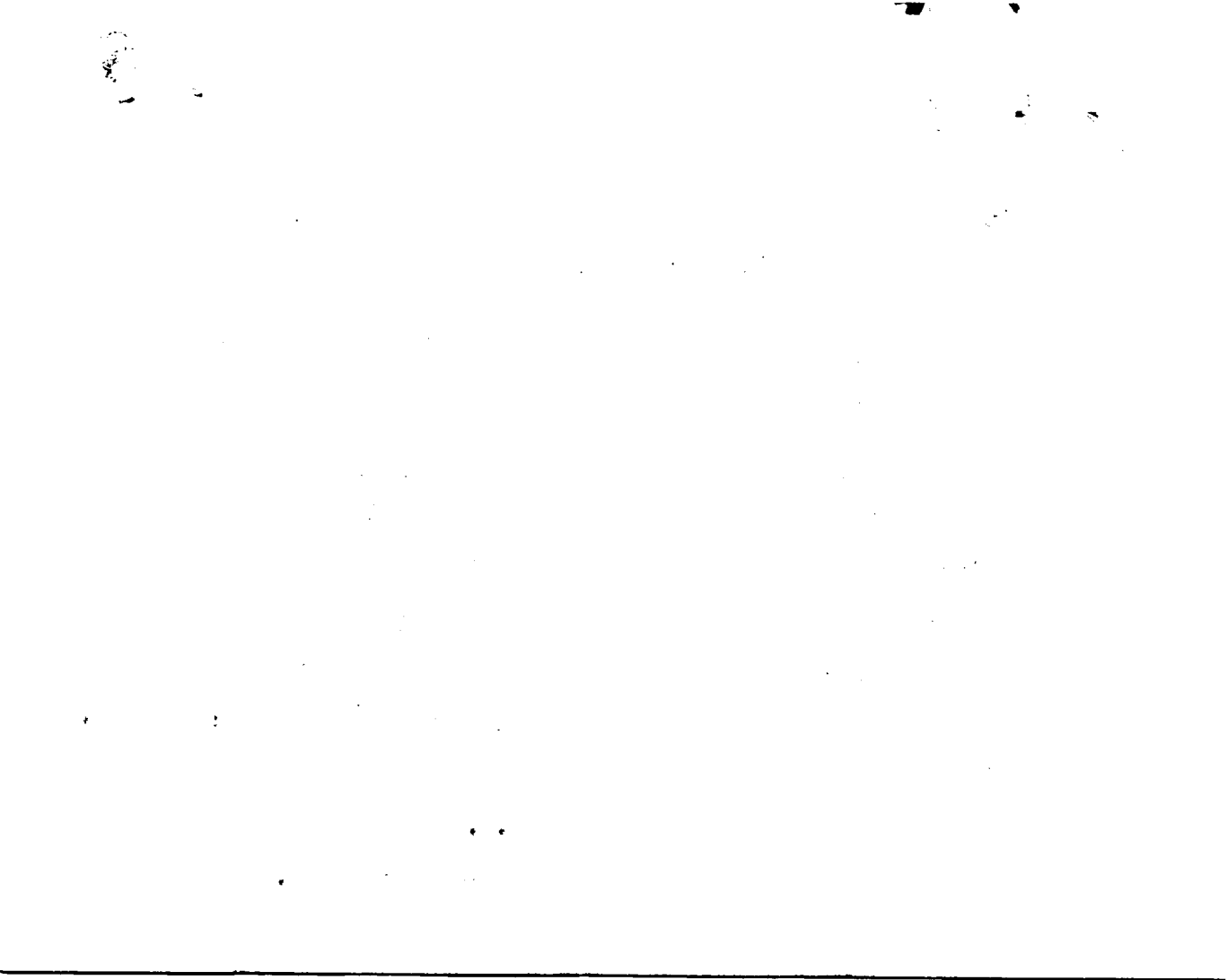
Filed

April 4 1924

Viola Allen

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bonner
City of Sandpoint

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 78Primary Registration District No. 2155

(No. _____ St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 44974

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH

March 25, 1924
(Month) (Day) (Year)

7. AGE

Stillborn

IF LESS than 1 day how many
_____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF

Father Dewey Bowker

11. BIRTHPLACE

OF FATHER Ohio
(State or Country)

12. MAIDEN NAME OF MOTHER

Agnes Esther Rasmussen

13. BIRTHPLACE OF MOTHER

(State or Country) Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Viola Allen
(Address) Sandpoint, Idaho.

15.

Filed March 26 1924 Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 25 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____,

that I last saw him alive on _____ 19____, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stillborn - eclampsia in mother.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) N. W. Valentine M. D.

3-26-1924 (Address) Sandpoint, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted

If not at place of death?

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Stanley 3/26 1924
Phinney Cemetery

20. UNDERTAKER

ADDRESS

S. A. Allen Sandpoint, Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

PLACE OF BIRTH

755-117009-459

County of BonnerCity of Sandpoint

No. St.

Registration District No. 78

State File No.

Hospital CityPrimary Registration District No. 2151

Local Registrar's No.

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>March 17</u> 192 <u>4</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1Number of child of this mother now living, including present birth 1

FULL NAME FATHER

Peter Pennington

FULL MAIDEN NAME

MOTHER

Laura Derr

RESIDENCE

716 N 5th Ave Sandpoint

RESIDENCE

716 N 5th Ave Sandpoint

COLOR

white

AGE AT LAST BIRTHDAY

31 (Years)

COLOR

white

AGE AT LAST BIRTHDAY

27 (Years)

BIRTHPLACE

Radcliff England

BIRTHPLACE

Upper Alton, Ill.

OCCUPATION

LABORER

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive Stillborn at 4 TP M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Floyd Gwendle

(Physician or midwife)

Address

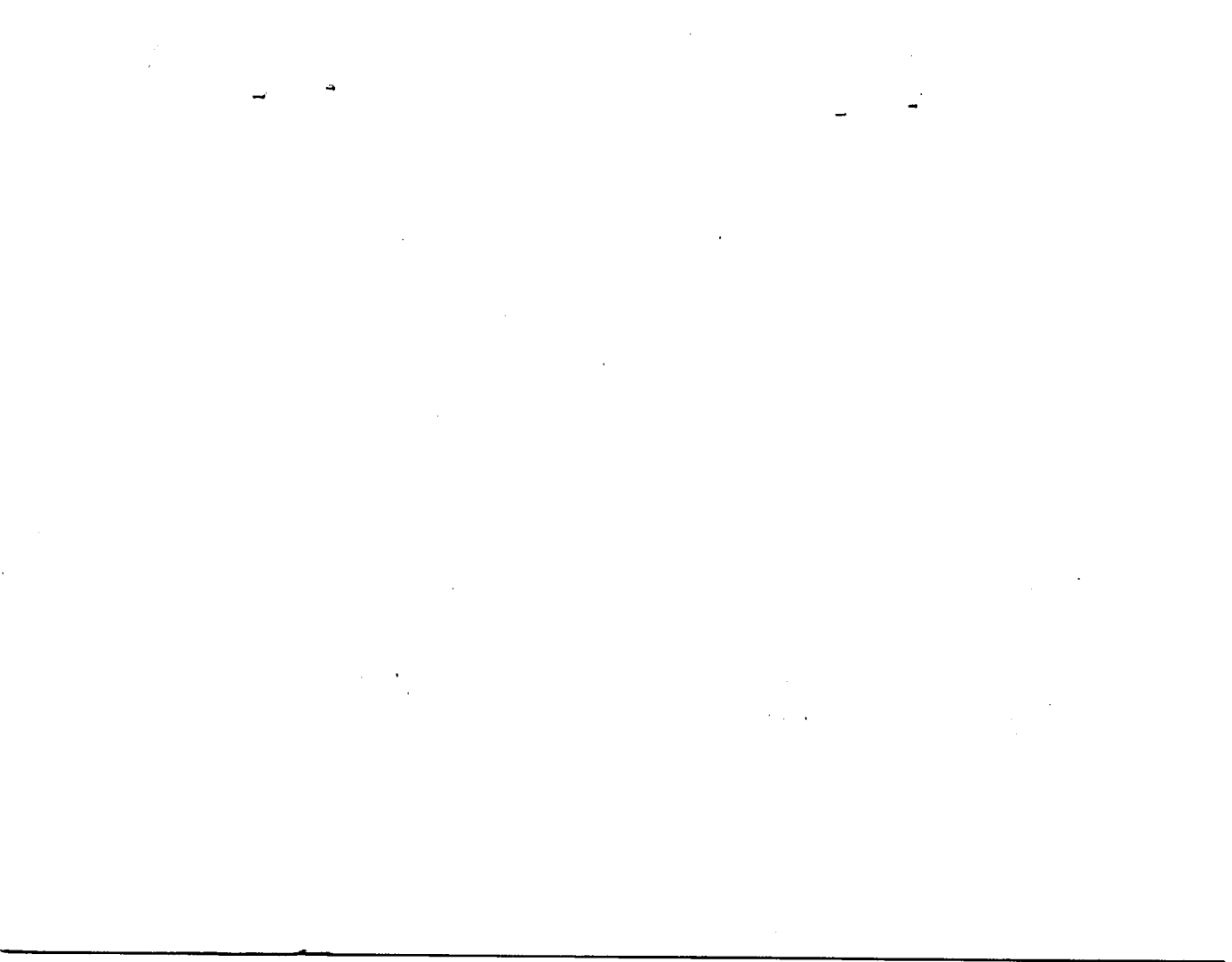
Sandpoint IdahoFiled April 4 1924Viola Allen

Deputy Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bonner
City of Sandpoint

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

"Baby" Pennington

RECEIVED CERTIFICATE OF DEATH

Registration District No. 78Registration District No. 2155(No. 5)

St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. 44978

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MaleWhiteSingle

(Write the word)

6. DATE OF BIRTH

March 17, 1924
(Month) (Day) (Year)

7. AGE

IF LESS than 1
day how many
hrs. or
mins.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

Infant.

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

Peter Pennington

11. BIRTHPLACE OF FATHER

(State or Country)

England.

12. MAIDEN NAME OF MOTHER

Laura Derr.

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

P. Pennington
716 N. 2nd Ave. Sandpoint

15.

Filed March 18 1924

Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 17, 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Stillborn 1924
that I last saw him alive on 1924

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Playa Allen M. D.3-18-1924 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....ds.
Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lakeview Cemetery 3/18 1924

20. UNDERTAKER

ADDRESS

W. H. Moon Sandpoint, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "**Laborer, Foreman, Manager, Dealer, etc.,** without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "**Epidemic cerebrospinal meningitis**"); **Diphtheria** (avoid use of "**Croup**"); **Typhoid fever** (never report "**Typhoid Pneumonia**"); **Lobar pneumonia; Bronchopneumonia** ("**Pneumonia**," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "**Cancer**" is less definite; avoid use of "**Tumor**" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "**Asthenia, Anaemia**" (merely symptomatic), "**Atrophy, Collapse, Coma, Convulsions, Debility, Congenital, Senile, etc., Dropsy, Exhaustion, Heart Failure, Hemorrhage, Inanition, Marasmus, Old age, Shock, Uraemia, Weakness, etc.,** when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "**Contributory.**"

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

275 213 016 316
County of Cassia

City of Declo

No. _____ St. _____

Hospital _____

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 117

File No. _____

Primary Registration District No. 2196

Registered No. 2790

FULL NAME OF CHILD Fern Bingham

(Certificate of no value without full name of child.)

Sex of Child	Female	Twin Triplet or other?	{ and }	Number in order of birth	Legiti- mate?	Yes	Date of birth	Mar	13	1924
							(Month)	(Day)	(Year)	

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FATHER
FULL NAME Leonard Paul Bingham
RESIDENCE Declo, Idaho
COLOR White AGE AT LAST BIRTHDAY 23
(Years)
BIRTHPLACE Franklin, Ariz
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Maryette Lawder
RESIDENCE Declo, Idaho
COLOR White AGE AT LAST BIRTHDAY 23
(Years)
BIRTHPLACE Grover, Wyo.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 1:35 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature) _____

Physician

(Physician or midwife)

Give names added from a supplemental report.

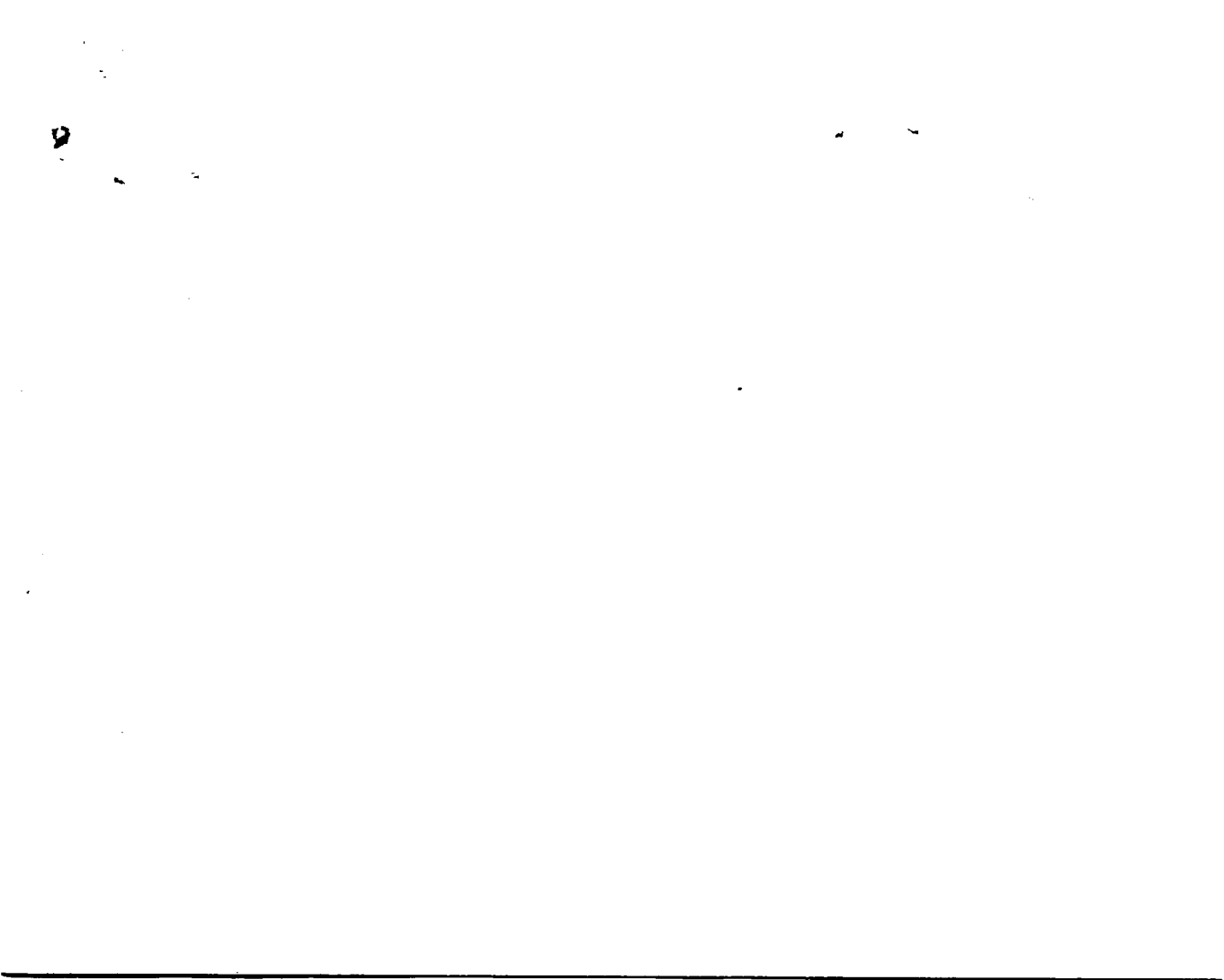
Address _____

Filed _____

4-1 1924

Registrar.

Registrar.



FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Cassia Registration District No. 117
City of Idaho Primary Registration District No. 2196
(No. St.)

File No. 450148
Registered No. 1698

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fern Bingham

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH March 13 1924
(Month) (Day) (Year)

7. AGE Stillborn IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Leonard Paul Bingham

11. BIRTHPLACE OF FATHER Arizona
(State or Country)

12. MAIDEN NAME OF MOTHER Maryette Lowder

13. BIRTHPLACE OF MOTHER Wyoming
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Copied from birth certificate
(Address)

15. Filed 4-1 1924 127c Patterson
Local Registrar

16. DATE OF DEATH March 13 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
.....19..... to19.....
that I last saw h..... alive on.....19.....
and that death occurred on the date stated above, at.....M.
The CAUSE OF DEATH* was as follows:

Stillbirth
(Duration) Yrs.....mos.....ds.
Contributory Prematurity
(Secondary) 7th month of gestation
(Duration) Yrs.....mos.....ds.
(Signed) C. A. Rich M. D.
3-13-1924 (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
.....19.....

20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

120394

County of Franklin
City of Preston
No. 862-20021512 St. Registration District No. 27 State File No. 2

Hospital _____ Primary Registration District No. 2119 Local Registrar's No. 41

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> }</u> and <u> {</u> Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Mar. 10</u> 192 <u>4</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? 2007. Cef.

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 3

FULL NAME	FATHER	FULL MAIDEN NAME	MOTHER
<u>Samuel D. Hobbs</u>		<u>Maudie Eakin</u>	
RESIDENCE	<u>Preston Ida.</u>	RESIDENCE	<u>Preston Ida.</u>
COLOR	<u>W</u> AGE AT LAST BIRTHDAY <u>32</u> (Years)	COLOR	<u>W</u> AGE AT LAST BIRTHDAY <u>32</u> (Years)
BIRTHPLACE	<u>Idaho</u>	BIRTHPLACE	<u>Wyoming Utah</u>
OCCUPATION	<u>Farming</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 11 A M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) G. R. Curtis

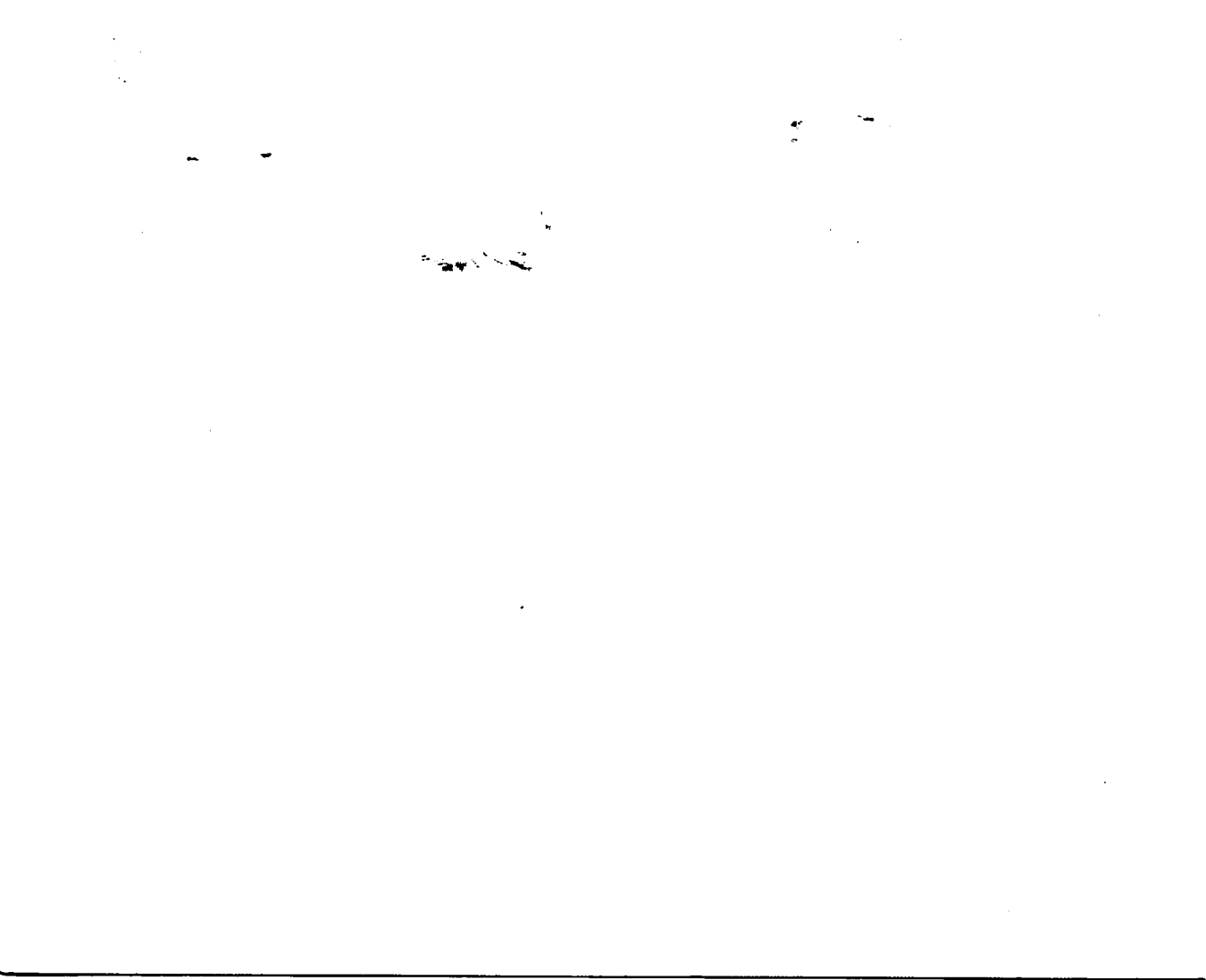
(Physician or midwife)

Address Preston Idaho

Filed Apr. 3 1924 Mrs. Ida Lippik

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Franklin
City of Preston

If death occurs away from usual residence, give facts called for under special information.

RECEIVED CERTIFICATE OF DEATH

Registration District No. 27
Primary Registration District No. 2119
(No. _____ St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 45019
Local Registrar's No. 23

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Stillborn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single
(Write the word)

6. DATE OF BIRTH

Mar. 10 1924
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many
0 hrs. or
0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Samuel S. Hobbs

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Maudie Eakin

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Samuel S. Hobbs

(Address)

Preston Idaho

15.

Filed Apr. 31924

Mrs. H. L. Tappan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar. 10 1924
(Month) (Day) (Year)

17. - I HEREBY CERTIFY, That I attended deceased from

Mar. 10 1924 to Mar. 10 1924

that I last saw her alive on Stillborn 19,
and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Erythraemia Monotonu
died at umb.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

A. R. Culler M. D.

19

(Address)

Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place ☒ In the
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Franklin Cemetery

DATE OF BURIAL

Mar. 10 1924

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

265-124-025-691
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Idaho
City of Brangerville
No. _____ St. _____
Registration District No. 103 File No. 120415
Hospital _____ Primary Registration District No. 2181 Registered No. 10
FULL NAME OF CHILD not named
(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other? _____ and _____ Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Mar 24</u> 192 <u>4</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth... 2 Number of child of this mother now living, including present birth... 2

FATHER		MOTHER	
FULL NAME	<u>Clarence Bonstrom</u>	FULL MAIDEN NAME	<u>Frankie Fray</u>
RESIDENCE	<u>Brangerville</u>	RESIDENCE	<u>Brangerville</u>
COLOR	<u>W</u>	COLOR	<u>W</u>
AGE AT LAST BIRTHDAY	<u>37</u> (Years)	AGE AT LAST BIRTHDAY	<u>32</u> (Years)
BIRTHPLACE	<u>Minn.</u>	BIRTHPLACE	<u>Mo.</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was... born dead 7:30 P. M.
on the date above stated. stillborn (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

_____, 19____

Registrar.

(Signature)

Address

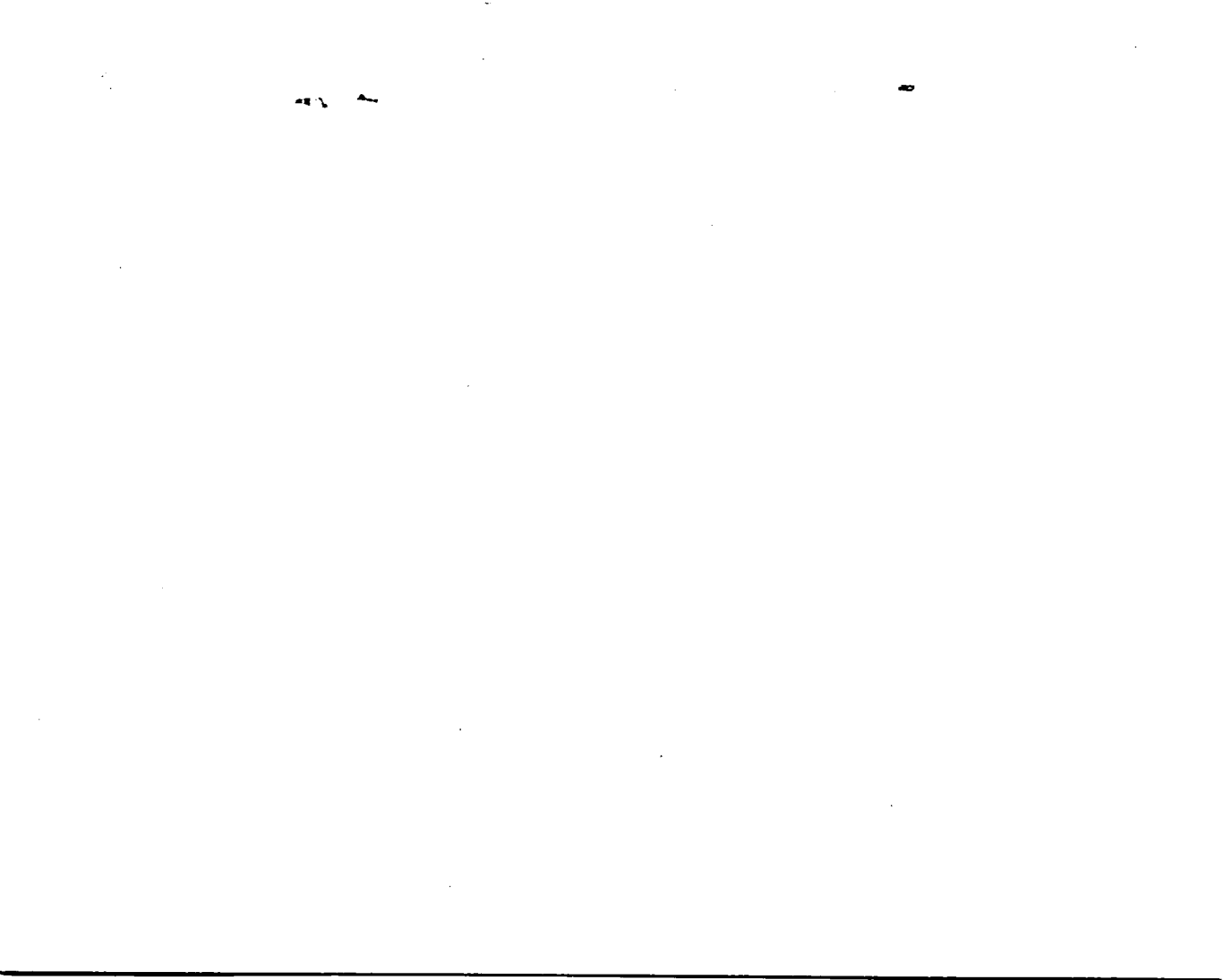
Filed

G. S. Strickton
(Physician or midwife)

Brangerville Ida

April 1, 1924 G. S. Strickton

Registrar.



CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho Registration District No. 103
City of Grangeville (No. 2181 St.)File No. 15020
Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Not Named

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Feb 24 1924
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)none

9. BIRTHPLACE

(State or Country)

Grangeville Ida

10. NAME OF FATHER

Clarence Bonstrom

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Frankie Gray

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence Bonstrom
(Address) Grangeville Ida15. Filed April 1 1924 H. S. Stricklin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 24 1924
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb 24 1924 to Feb 24 1924 that I last saw him alive on Feb 24 1924 and that death occurred on the date stated above, at 19 M.

The CAUSE OF DEATH* was as follows:

died in utero
Cause unknown

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. S. Stricklin M. D.3/4 1924 (Address) Grangeville Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brairie View3/25 1924

20. UNDERTAKER

ADDRESS

none

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING
WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

251-116 029869

Form V. S. No. 11-0-22-33-17

PLACE OF BIRTH *Latah* RECEIVED *STATE OF IDAHO*
BUREAU OF VITAL STATISTICS
County of *Latah* APR 11 1924 CERTIFICATE OF BIRTH *S*
City of *Genesee* *62* *120467*
Registration District No. File No.

No. *2142* Primary Registration District No. Registered No. *4*
Hospital *Still Born*
FULL NAME OF CHILD *Still Born*

Sex of Child <i>M</i>	Twin Triplet or other? <i>—</i> and in order of birth <i>—</i> (To be answered only in event of plural births)	Legitimate? <i>yes</i>	Date of Birth <i>3 16 24</i> (Month) (Day) (Year)
FATHER FULL NAME <i>Joseph Knapp</i> RESIDENCE <i>Genesee</i> COLOR <i>W</i> AGE AT LAST BIRTHDAY <i>32</i> (Years) BIRTHPLACE <i>Penn</i> OCCUPATION <i>Retired Fireman</i>		MOTHER FULL MAIDEN NAME <i>Josephine Hornum</i> RESIDENCE <i>Genesee</i> COLOR <i>W</i> AGE AT LAST BIRTHDAY <i>42</i> (Years) BIRTHPLACE <i>Mio</i> OCCUPATION <i>Housewife</i>	

Number of child of this mother, including present birth *2* Number of children of this mother now living, including present birth *0*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *24* at the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *W. E. Ehem*
(Physician or midwife)

Given names added from a supplemental report.

Address *3-17-24*
Filed *W. E. Ehem*
Registrar

FORM V. S. No. 5-25 M. 1-19.

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

Registration District No.

Registration District No.

(No.)

(St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Died with
undeveloped
lungs (days before birth)

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

L. O. E. H. M. D.

3-17-1924 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Nez Perce
City of Julesburg RPP
No. 652-219 035-796 St. Registration District No. 68 File No. 120513
Hospital _____ Primary Registration District No. _____ Registered No. _____
FULL NAME OF CHILD Shelborn Mestling
(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Feb. 19</u> 192 <u>4</u> (Month) (Day) (Year)
----------------------------	------------------------------	-----------	--------------------------------	------------------------	---

(To be answered only in event of plural births)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth _____ Number of child of this mother now living, including present birth _____

FATHER FULL NAME <u>Charles A. Mestling</u>	MOTHER FULL MAIDEN NAME <u>Gussie Grochse</u>
RESIDENCE <u>Julesburg, Ida.</u>	RESIDENCE <u>same</u>
COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>34</u> (Years)	COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>21</u> (Years)
BIRTHPLACE <u>Minn.</u>	BIRTHPLACE <u>Virginia</u>
OCCUPATION <u>farmer</u>	OCCUPATION <u>housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Shelborn (Born alive or stillborn) at B. A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Trifan F. Stahl

(Physician or midwife)

Give names added from a supplemental report.

Address Lewiston, Ida.

Filed Feb 20 1924

Registrar.

Registrar.

2



A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

RECEIVED

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Owyhee

APR 3 1924

CERTIFICATE OF BIRTH

City of Malad

No. 261-112036-655

BUREAU OF VITAL

St. Boise District No. 26

State File No.

Hospital

Primary Registration District No. 2069

Local Registrar's No. 42

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child Male

Twin
Triplet
or other?
(To be answered only in event of plural births)

and { Number
in order
of birth
(To be answered only in event of plural births)

Legitimate? Yes

Date of birth 3-12-1924
(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 6

Number of child of this mother now living, including present birth 4

FULL NAME

FATHER

G. B. Dewar

RESIDENCE

Malad

COLOR

White

AGE AT LAST BIRTHDAY 39
(Years)

BIRTHPLACE

Switzerland

OCCUPATION

Farmer

FULL MAIDEN NAME

MOTHER

Freda Fisher

RESIDENCE

Malad

COLOR

White

AGE AT LAST BIRTHDAY 33
(Years)

BIRTHPLACE

Switzerland

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at Malad M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

Malad, Ida
8/31 1924

Registrar.

Registrar



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

3647246 086-313
PLACE OF BIRTH

RECEIVED DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Shoshone
City of Kellogg
No. California St.

APR 7 1924

CERTIFICATE OF BIRTH

Registration District No. 123

File No. 120572

Hospital.....

Primary Registration District No. 17

Registered No. 17

FULL NAME OF CHILD.....

(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>2/16/</u> (Month) (Day) (Year) <u>1924</u>
----------------------------	---	---	-----------------------------	---

What bactericidal solution was used in eyes?.....

Number of child of this mother, including present birth..... 4

Number of child of this mother now living, including present birth..... 2

FULL NAME FATHER Jos Camilli

FULL MAIDEN NAME MOTHER Jessie - Calderro

RESIDENCE Kellogg

RESIDENCE Kellogg

COLOR White AGE AT LAST BIRTHDAY..... (Years)

COLOR White AGE AT LAST BIRTHDAY..... (Years)

BIRTHPLACE Italy

BIRTHPLACE Italy

OCCUPATION Mill-man

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was..... Stillborn..... at..... 1 P...... M.
on the date above stated.

(Born alive or stillborn)

* When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

A. S. Macdonald M.D.

(Physician or midwife)

Give names added from a supplemental report.

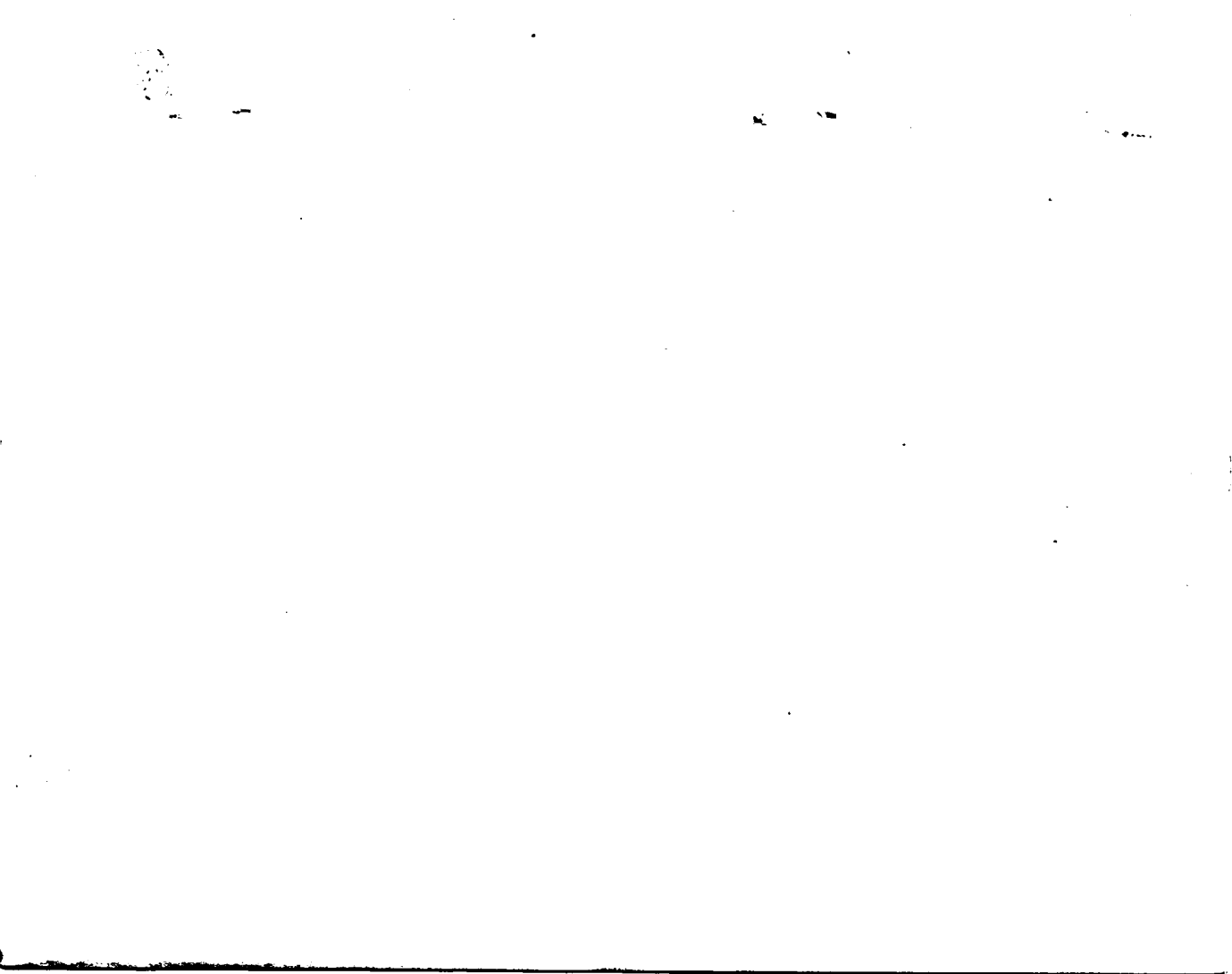
Address.....

Filed.....

1924

Registrar.

Registrar.



CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Shoshone*

City of *Kellogg*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Comalli

Registration District No. *123*

Primary Registration District No. *—*

(No. *—*)

(St. *—*)

File No. *25097*

Registered No. *14*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single (use word.)

6. DATE OF BIRTH

Feb 16

(Month)

(Day)

1904
(Year)

7. AGE

Died at birth

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kellogg Idaho

10. NAME OF FATHER

Joseph Comalli

11. BIRTHPLACE OF FATHER

(State or Country)

Besano Italy

12. MAIDEN NAME OF MOTHER

Caldarara France

13. BIRTHPLACE OF MOTHER

(State or Country)

Bisuschia Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Comalli

(Address)

Kellogg Idaho

15.

Filed

3/24/24

E. E. Hardy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb

16

1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

2/16/1924

19

that I last saw him alive on

and that death occurred on the date stated above, at *12:30 P.*
The CAUSE OF DEATH* was as follows:

Still birth

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

A. D. Thompson

M. D.

2/17/24

(Address)

Kellogg Idaho

*State the Disease Causing Death; or in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Greenwood Cem

DATE OF BURIAL

Feb 17 1924

20. UNDERTAKER

McManis

ADDRESS

Kellogg Idaho

65a
66
V 8 10

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary); may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

666123.042496

PLACE OF BIRTH

RECEIVED

Form V.-S. No. 17C-25m-7-21-19

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

County of Twin Falls BUREAU OF VITAL STATISTICS

City of Twin Falls BUREAU OF VITAL STATISTICS

Registration District No. 37 File No. 120582

No. _____ St. _____

Hospital _____ Primary Registration District No. 2085 Registered No. _____

FULL NAME OF CHILD Gleam Woods

Sex of Child Male Twin or other? — { and { Number in order of birth — Legiti mate? yes Date of Birth 2-23 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER
FULL NAME Frank Woods
RESIDENCE Twin Falls
COLOR white AGE AT LAST BIRTHDAY 35 (Years)
BIRTHPLACE Nebraska
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Clara Frost
RESIDENCE Twin Falls
COLOR white AGE AT LAST BIRTHDAY 27 (Years)
BIRTHPLACE Alabama
OCCUPATION Housewife

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born Still Born at 7 A.M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. N. Lute
Twin Falls Ida
(Physician or midwife)

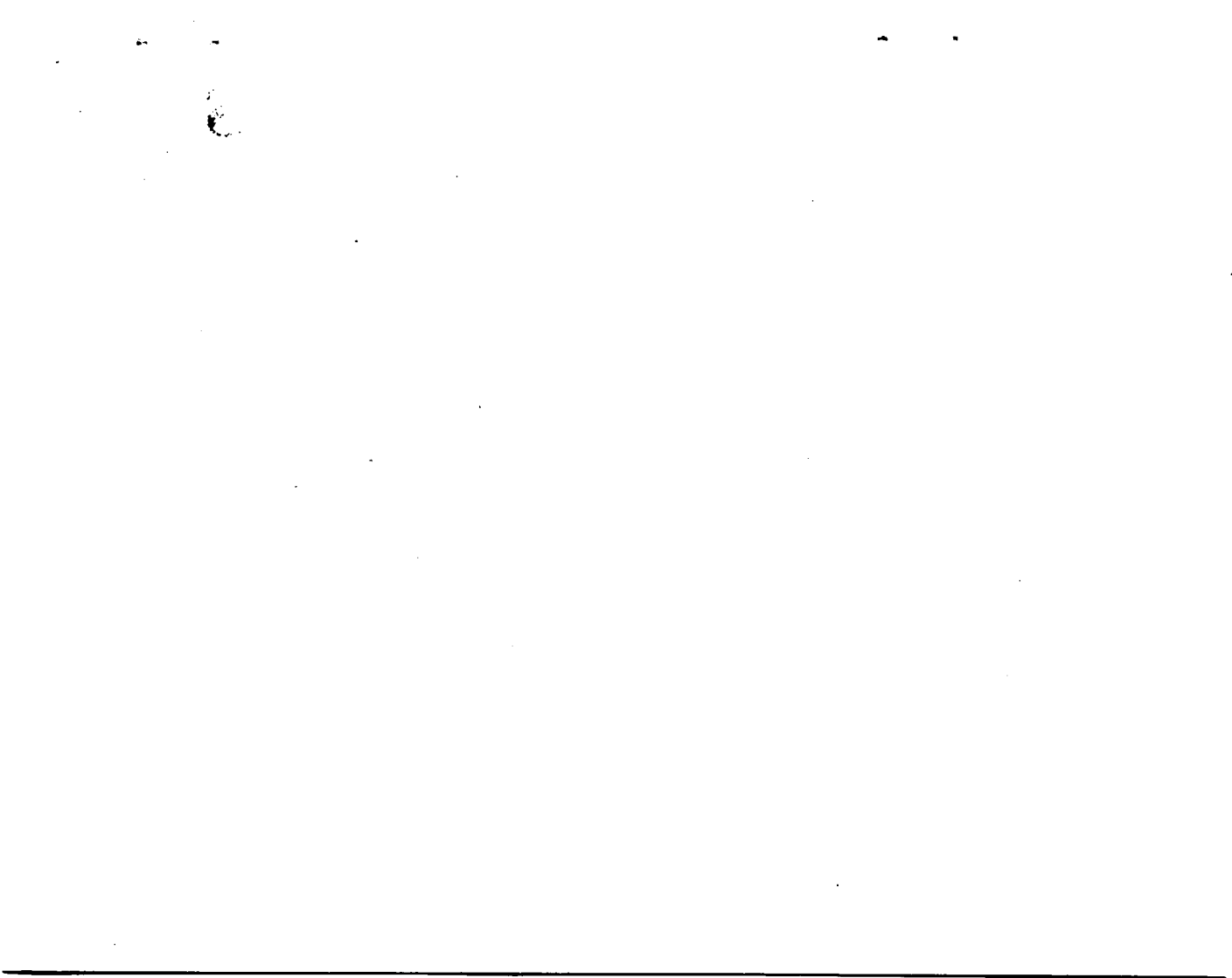
Given names added from a supplemental report.

19

Address _____

Filed Apr 11 1- 1924 John F. Connelley
Registrar

Registrar



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM. V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Lewin Falls Registration District No. 37
City of " Primary Registration District No. 2085
(No. Lewin Falls RFD St.)
If death occurs away from usual residence, give facts called for under special information.

State File No. 14873
Local Registrar's No. 14873
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Glenn Armeur Woods

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH Feb. 23, 1924
(Month) (Day) (Year)

7. AGE — Yrs. — Mos. — ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE (State or Country) Lewin Falls,

10. NAME OF FATHER G. Frank Woods

11. BIRTHPLACE OF FATHER (State or Country) Neb.

12. MAIDEN NAME OF MOTHER Clara M. Frost

13. BIRTHPLACE OF MOTHER (State or Country) Ala.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) G. Frank Woods
(Address) Lewin Falls, Ida.

15. Filed Feb. 1, 1924 John A. Laughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 23, 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/23 1924 to Jan 23 1924, that I last saw him alive on 2/23 1924 and that death occurred on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows:

Steel Bomb
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) H. H. Lette M. D.
4/26 1924 (Address) Lewin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lewin Falls, Ida. DATE OF BURIAL 2-24 1924

20. UNDERTAKER H. J. Grossman ADDRESS Lewin Falls, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

28 2. 202 042 533

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Twin Falls

RECEIVED

APR 11 1924

CERTIFICATE OF BIRTH

City of Buhl

BUREAU OF VITAL STATISTICS

No. _____ St. _____

Registration District No. _____

39

File No. 120620

Hospital _____

Primary Registration District No. 2087

Registered No. _____

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____ { and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>3</u> <u>2</u> <u>1924</u> (Month) (Day) (Year)
----------------------------	---	------------------------	---

What bactericidal solution was used in eyes? Argisol 202

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FULL NAME <u>FATHER</u> <u>Roy L Bybee</u>	FULL MAIDEN NAME <u>MOTHER</u> <u>Margaret Ellis</u>
RESIDENCE <u>Buhl</u>	RESIDENCE <u>Buhl</u>
COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>25</u> (Years)	COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>Mo.</u>	BIRTHPLACE <u>Mo.</u>
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 8:00 M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

_____, 19____

Registrar.

(Signature)

Address

Filed APR 1 1924

Registrar.

6

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. R.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Lewis & Clark
City of Bozeman

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
CERTIFICATE OF DEATH

Registration District No. 39
Primary Registration District No. 2087
(No. 1111 St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 45100
Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female White Single
(Write the word)

6. DATE OF BIRTH

March 4 1924
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
✓ Yrs. ✓ Mos. ✓ ds. ✓ hrs. or ✓ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work X
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Bozeman Idaho

10. NAME OF Father

11. BIRTHPLACE OF FATHER

(State or Country) Missouri

12. MAIDEN NAME OF MOTHER

Margaret Ellis

13. BIRTHPLACE OF MOTHER

(State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy J. Bybee
(Address)

15.

Filed 3-3 1924 J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 2 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3/1 1924 to 3/2 1924

that I last saw her alive 19

and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Some unknown cause operating before labor, which had been dead 3 or 4 days on delivery
(Duration) — yrs. — mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) A. P. Hughes M. D.

3/3 1924 (Address) Bozeman Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place — In the
of death — yrs. — mos. — days. State — yrs. — mos. — ds.
Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Bozeman Idaho 3/3 1924

20. UNDERTAKER

L. D. Hughes Bozeman, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

DATE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

120622

County of Clayton
City of Roseworth
No. 915-206-037815 St.
Hospital _____

Registration District No. 39 File No. _____
Primary Registration District No. 2087 Registered No. _____

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____ { and } Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>3</u> <u>6</u> <u>1924</u> (Month) (Day) (Year)
----------------------------	---	------------------------	---

What bactericidal solution was used in eyes? Argyrol 20%

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME William W. Winegar
RESIDENCE Roseworth
COLOR white AGE AT LAST BIRTHDAY 28
(Years)
BIRTHPLACE Utah
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Clara Hanson
RESIDENCE Roseworth
COLOR white AGE AT LAST BIRTHDAY 18
(Years)
BIRTHPLACE S. D.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn 6:45 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 19____

Registrar.

(Signature)

Address

Filed

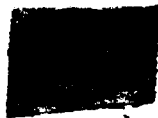
A. J. Murphy

Phyllis
(Physician or midwife)

Bush

APR 1 1924

J. H. Murphy
Registrar.



20

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Cuyahoga
City of Roseworth

Registration District No. 2087

State File No. 45101

Local Registrar's No. 45101

If death occurs away from usual residence, give facts called for under special information.

(No. 2087 St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Daley Winegar

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

white

Single
(Write the word)

6. DATE OF BIRTH

March 6 1924
(Month) (Day) (Year)

7. AGE

X Yrs X Mos. X ds.

IF LESS than 1 day how many
X hrs. or X min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Roseworth

10. NAME OF FATHER

Father

W. W. Winegar

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Mother

Mrs. Hansen

13. BIRTHPLACE OF MOTHER

(State or Country)

So. Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. W. Winegar
Roseworth

15.

Filed 3-7

1924

J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 6 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 6 1924 to March 6 1924
that I last saw deceased on March 6 1924

and that death occurred on the date stated above, at 4 PM

The CAUSE OF DEATH* was as follows:

Septic Placenta
Ex. Ac. Post. Presentation
Forceps Del. Perforation
(Duration) hrs. mos. ds.

Contributory

(Secondary)

(Duration) hrs. mos. ds.

(Signed)

W. W. Winegar M. D.

3/7 1924 (Address) Buhl Bldg

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death hrs. mos. days. In the State hrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Buhl Bldg

DATE OF BURIAL

3/7 1924

20. UNDERTAKER

J. H. Murphy

ADDRESS

Buhl Bldg

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH 819-121044-469
County of Washington
City of Weiser Idaho
No. Wendell Hospital St. Registration District No. 86 State File No. 120645
Hospital..... Primary Registration District No. 1010 Local Registrar's No. 7

FULL NAME OF CHILD Baby Hargrove
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? <u>and</u> { <u>Number in order of birth</u> }	Legitimate? <u>yes</u>	Date of Birth <u>1-21</u> , 192 <u>4</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? No

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Claude C. Hargrove</u>	<u>Weiser Idaho</u>	<u>Alma Morehead</u>	<u>Weiser Idaho</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>42</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)
BIRTHPLACE <u>Cuba Kentucky</u>		BIRTHPLACE <u>Midvale Idaho</u>	
OCCUPATION <u>Manager Ford Garage</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn { Dead-alive } at 7:45 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Ernest O. Finney

(Physician or midwife)

Give names added from a supplemental report.

Address 4621st

Filed 1924

Registrar.

Registrar.

8

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

Station No.

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
- (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19. (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19.

that I last saw h. alive on 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

1924

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *A school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Ada

MAY 5 1924

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

120693

City of Boise

No. 266-218001-99

St.

Registration District No.

State File No.

Hospital St. Luke's

Primary Registration District No.

Local Registrar's No.

FULL NAME OF CHILD

Elizabeth Ann Bowen

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>No</u>	and { Number in order of birth <u>1</u> }	Legitimate? <u>Yes</u>	Date of birth <u>3-18-1924</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes? 1% Silver Nitrate Sol.

Number of child of this mother, including present birth 1

Number of child of this mother now living, including present birth 0

FATHER	MOTHER
FULL NAME <u>L. Browder Bowen</u>	FULL MAIDEN NAME <u>Ethel F. Richert</u>
RESIDENCE <u>1314 N. 18th St. Boise, Ida</u>	RESIDENCE <u>1314 N. 18th St. Boise, Ida</u>
COLOR <u>White</u>	COLOR <u>White</u>
AGE AT LAST BIRTHDAY <u>36</u> (Years)	AGE AT LAST BIRTHDAY <u>30</u> (Years)
BIRTHPLACE <u>Kentucky</u>	BIRTHPLACE <u>Nebraska</u>
OCCUPATION <u>Teacher</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 9:28 a.m.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Dr. T. N. Braxton

Physician

(Physician or midwife)

Address

Boise, Idaho

Filed

Apr 30 1924

R. J. Pax

Registrar.

Registrar.

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ADJUTANT GENERAL RESERVE FOR BINDING
"WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should
state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is
very important. See instructions on back of certificate."

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Ada

City of Bain

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Elizabeth Ann Bowen

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1204

(No. St. Lukes Hospital St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 44919

Local Registrar's No. 81

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH

Mar 18 1924
(Month) (Day) (Year)

7. AGE

IF LESS than 1
day how many
— hrs. or
— Yrs. — Mos. — ds. — min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

None

9. BIRTHPLACE

(State or Country)

10. NAME OF

Father R. Browder Bowen

11. BIRTHPLACE

OF FATHER (State or Country) Kentucky

12. MAIDEN NAME

OF MOTHER Ethel F. Rickett

13. BIRTHPLACE

OF MOTHER (State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. Browder Bowen

(Address)

15.

Filed Mar 19 1924 Res. Dist.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 18 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Mar 18 1924 to Mar 18 1924,

that I last saw her alive on Mar 18 1924
and that death occurred on the date stated above, at 9:30 A.

The CAUSE OF DEATH* was as follows:

Uterine Inertia
Slow Labor. Still Born

(Duration) yrs. mos. 12 hr

Contributory Breech Case
(Secondary)

(Duration) yrs. mos. ds.

(Signed) T. W. Brantigan M. D.

Mar 19 1924 (Address) Bain Idaho

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cem.

DATE OF BURIAL
Mar 19 1924

20. UNDERTAKER

Summers & Sons

ADDRESS

Bain Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

811-210-803-843

APR 22 1924

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S
120795

County of Pannock
City of Pocatello
No. _____ St. _____ Registration District No. 28 State File No. _____
Hospital St. Anthony's Temporary Registration District No. 2141 Local Registrar's No. 6341

FULL NAME OF CHILD Nellie Helen Haas
(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? 1 and { Number in order of birth 1 Legitimate? Yes Date of birth March 10, 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Silver nitrate, 1 drop gets, each eye

FATHER		MOTHER	
Number of child of this mother, including present birth	<u>2</u>	Number of child of this mother now living, including present birth	<u>1</u>
FULL NAME	<u>Laurence Edward Haas</u>	FULL MAIDEN NAME	<u>Mrs. Hulse</u>
RESIDENCE	<u>Park ave.</u>	RESIDENCE	<u>Park ave.</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>29</u> (Years)	AGE AT LAST BIRTHDAY	<u>21</u> (Years)
BIRTHPLACE	<u>Beatown Wis.</u>	BIRTHPLACE	<u>M^cCammon Ida.</u>
OCCUPATION	<u>Blacksmith</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 7:30 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Dr. A. M. Newton
(Physician or midwife)

Address Pocatello
Filed 4/11 1924 Idaho Registrar.

Registrar.

SECRET

CONFIDENTIAL

OTHER

AGENT

SECRET

CONFIDENTIAL

CONFIDENTIAL

SECRET

CONFIDENTIAL

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth (CITY Pocatello
(ST. Idaho
(COUNTY Bannock

FILE NO. 123725

DATE OF BIRTH Mar. 10, 1924

SEX OF CHILD Female

FATHER L.E. Haas

MOTHER Mlle Hulse
(MAIDEN NAME)

I HEREBY CERTIFY that the child herein described has been named:

Nellie Helen Haas

Mrs L E. Haas
Signature of Father or Mother.

MAY 21 1924
BUREAU OF VITAL
STATISTICS

Why is it Necessary to have the
named when it was Borne & a
I have put down the name we
of named it if she had of lived

Mrs Lawrence E. H.
461 Park ave
Pocatello
Id

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bannock Registration District No. 28City of Pocatello Primary Registration District No. 2161

If death occurs away from usual residence, give facts called for under special information.

(No. St Anthony's Hosp)State File No. 45225Local Registrar's No. 4278

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Infant. Hoas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED single

6. DATE OF BIRTH

Nov 10 1924
(Month) (Day) (Year)

7. AGE

Still born
IF LESS than 1 day how many hrs. or min.?
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)none

9. BIRTHPLACE

(State or Country)

Pocatello Idaho

10. NAME OF

Father

Lawrence E. Hoas

11. BIRTHPLACE

OF FATHER

(State or Country)

Wisconsin

12. MAIDEN NAME

OF MOTHER

Mrs. Irene Hulse

13. BIRTHPLACE

OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lawrence E. Hoas
(Address) Pocatello, Idaho

15.

Filed 3/10 1927

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar. 10 1924
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
March 10 1924 to March 10 1924,that I last saw h. alive on March 10 1924,
and that death occurred on the date stated above, at 7:30 A. M.

The CAUSE OF DEATH* was as follows:

Still birth. Probably the result of mother having influenza with severe cough

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Am. Norton M. D.3/10 1924 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

If not at place of death?

Former or usual residence Bainbridge Pocatello

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. View Pocatello Mar. 10 1924

20. UNDERTAKER

ADDRESS

Mc Han and Co. Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

Mentor

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

168-123-003-846

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock

APR 22 1924

CERTIFICATE OF BIRTH

City of PaicinesNo. 14047 3rd

St.

Registration District No. 28State File No. 120817

Hospital

Primary Registration District No. 2167Local Registrar's No. 6380

FULL NAME OF CHILD

John Wesley Johnson
(Certificate of no value without full name of child)Sex of
ChildboyTwin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?yesDate of
birth3-231924

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 6Number of child of this mother now living, including present birth 1FULL
NAME

FATHER

Arthur Johnson

RESIDENCE

Paicines

COLOR

BlackAGE AT LAST
BIRTHDAY49
(Years)

BIRTHPLACE

Georgia

OCCUPATION

FarmerFULL
MAIDEN
NAME

MOTHER

Ide May Huff

RESIDENCE

same

COLOR

wAGE AT LAST
BIRTHDAY31
(Years)

BIRTHPLACE

Alabama

OCCUPATION

hus

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was { Born alive } at 11:00 M.
on the date above stated. { Stillborn }

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

J. H. Young

(Physician or midwife)

Address

Paicines

Filed

4/1, 1924

Registrar.

Registrar.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 11-28-2001 BY 60322 UCBAW/STP

Register

195

Give names added from a supplemental report.
 *When there was no attending physician or midwife then the right hand should be left blank. A signature etc. should make this report. A signature should be one that is not written and shows other evidence of the date.

on the date above stated.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was (MILKMAN) (born after) (Residence of child)

OCCUPATION

OCCUPATION

BIRTHPLACE

BIRTHPLACE

COLORED

AGE AT LAST BIRTHDAY

RESIDENCE

RESIDENCE

NAME
FATHER

NAME
MOTHER

Number of child of this mother, including present birth

Number of child of this father, including present birth

(Child)

Is he married only to (name of wife)

(Birth)

(Date of birth)

BUILD & TYPE OF CHILD

INVESTIGATION OF BIRTH

STATE OF OHIO

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho

MAY 16 1924

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY Pocatello
(ST. Ida
(COUNTY Bannock

FILE NO. 123 17
DATE OF BIRTH 3/22/24
SEX OF CHILD Male +

FATHER A.W. Johnson

MOTHER Eda A. Johnson
(MAIDEN NAME) Huff

I HEREBY CERTIFY that the child herein described has been named:

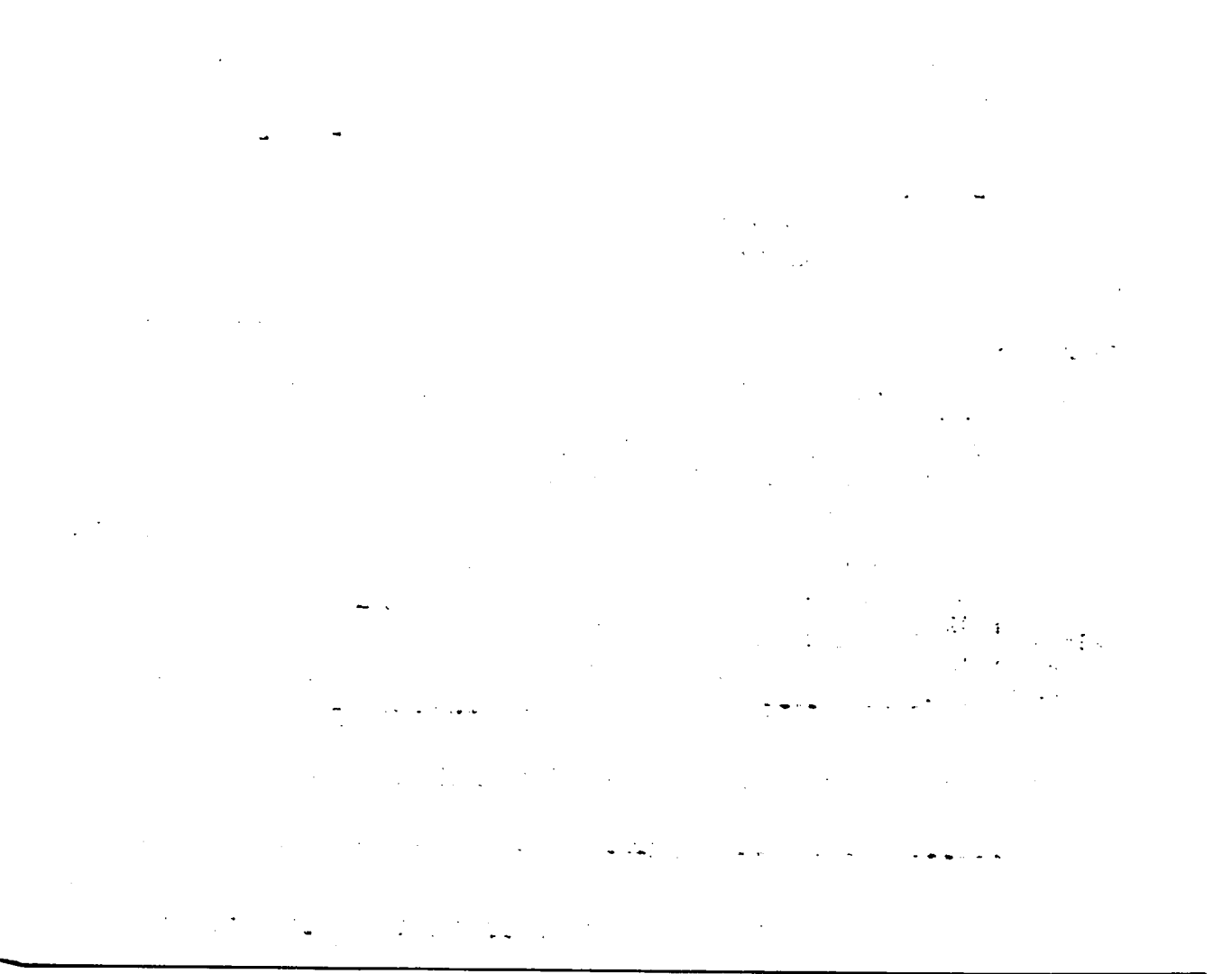
John Wesley Johnson

RECEIVED

MAY 22 1924

Arthur W. Johnson

Signature of Father or Mother.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

1. PLACE OF DEATH

County of Bannock
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2161
(No. 1409 M. 3rd St.)

John Wesley Johnson

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 45236Local Registrar's No. 4290

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

Mar 23 1924
(Month) (Day) (Year)

7. AGE

Stillborn IF LESS than 1 day how many
hrs. or min.?
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

none

9. BIRTHPLACE

(State or Country) Pocatello, Ida.

10. NAME OF FATHER

Arthur Johnson

11. BIRTHPLACE OF FATHER

(State or Country) Georgia

12. MAIDEN NAME OF MOTHER

Ida M. Huff

13. BIRTHPLACE OF MOTHER

(State or Country) Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur Johnson
(Address) Pocatello, Ida.

15.

Filed Mar 24 1924
Local Registrar W. H. H. H.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 23 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/23 1924, to 3-24 1924

that I last saw him at home 3/23 1924
and that death occurred on the date stated above, at 11:42 A.M.

The CAUSE OF DEATH* was as follows:

Stillborn -
Brach. Delivery - Contacted
pelvis. (Rabbit)
(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. H. H. H. M. D.
(Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

MT. View Cem.

DATE OF BURIAL

Mar 24 1924

20. UNDERTAKER

McHann & Co. Pocatello

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

363405.003-293

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTHCounty of SanuelCity of ParadiseRegistration District No. 28

File No.

S
120835No. 854th Nayo St.Primary Registration District No. 2161Registered No. 6398

Hospital

FULL NAME OF CHILD

ReilmanSex of
ChildmaleTwin
Triplet
or other?

{ and }

Number
in order
of birth

(To be answered only in event of plural births)

Legiti
mate?yesDate of
Birth40 - 5 - 24

(Month)

(Day)

1924
(Year)FULL
NAME

FATHER

Lee Ray Salmer

RESIDENCE

853rd Nayo

COLOR

whiteAGE AT LAST
BIRTHDAY30
(Years)

BIRTHPLACE

Missouri

OCCUPATION

Laundry DriverFULL
MAIDEN
NAME

MOTHER

Sumner Wells

RESIDENCE

853rd Nayo

COLOR

whiteAGE AT LAST
BIRTHDAY30
(Years)

BIRTHPLACE

Idaho

OCCUPATION

HousewifeNumber of child of this mother, including present birth, 3Number of children of this mother now living, including present birth, 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Reilman, at 74 M.
on the date above stated.

(Born alive or stillborn)

{ When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth. }

(Signature)

Shysecain
(Physician or midwife)

Given names added from a supplemental report.

19

Address

Paradise

Filed

4/15/24

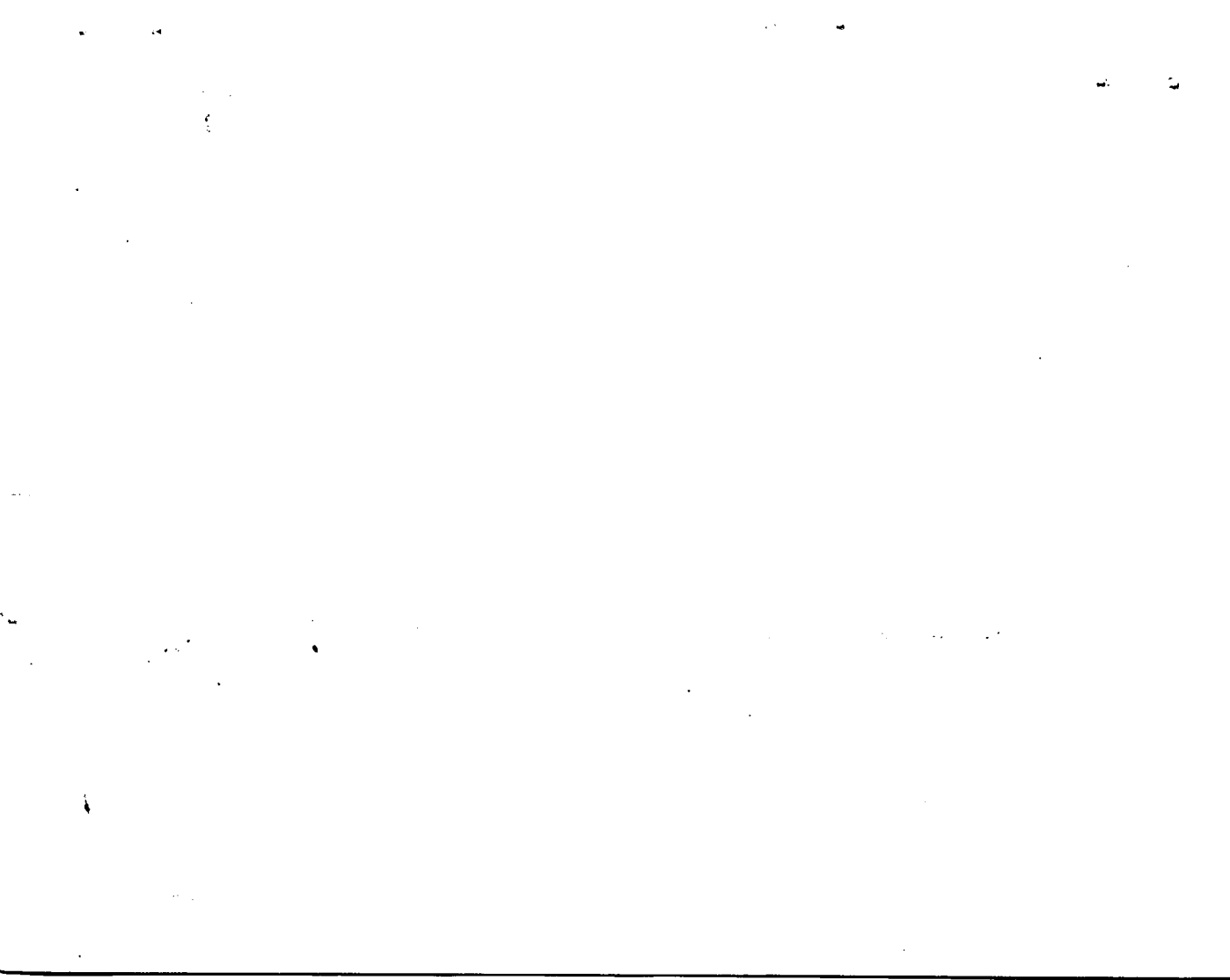
Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bannock Registration District No. 28City of Conatello Registration District No. 2161
MAY 18 1924 North Hager St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant LatimerState File No. 45181Local Registrar's No. 4305

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

WhiteInfant
(Write the word)

6. DATE OF BIRTH

April 5 1924
(Month) (Day) (Year)

7. AGE

StillbornIF LESS than 1 day how many
..... hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Infant

9. BIRTHPLACE

(State or Country)

Conatello Idaho

10. NAME OF

Father

L. R. Latimer

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Louella Bills

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. R. Latimer

(Address)

Conatello

15.

Filed

4/51924W. J. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 5 1924
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from April 5 1924 to April 5 1924, that I last saw him on April 5 1924, and that death occurred on the date stated above, at 7:41 M.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

1924 (Address)J. R. Brown M. D.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mountain View Cem

DATE OF BURIAL

April 5 1924

20. UNDERTAKER

Schumacher & Hall

ADDRESS

Conatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

69-205-005-693
PLACE OF BIRTH

RECEIVED
MAY 14 1924

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S
120868

CERTIFICATE OF BIRTH

County of Bennett
City of St. Maries
No. _____ St. _____ Registration District No. 32 State File No. _____
Hospital _____ Primary Registration District No. 2049 Local Registrar's No. 36
FULL NAME OF CHILD Pauline Alice Fiedler
(Certificate of no value without full name of child)

Sex of Child <u>female</u>	Twin Triplet or other? <u>-</u>	Number in order of birth <u>-</u>	Legiti- mate? <u>yo</u>	Date of birth <u>Apr 5</u> 192 <u>4</u> (Month) (Day) (Year)
What bactericidal solution was used in eyes? _____				

Number of child of this mother, including present birth <u>1</u>	Number of child of this mother now living, including present birth <u>0</u>
FATHER FULL NAME <u>Gus W. Fiedler</u> RESIDENCE <u>St. Maries Ida</u> COLOR <u>White</u> AGE AT LAST BIRTHDAY _____ (Years) BIRTHPLACE <u>Sonora</u> OCCUPATION <u>Truck driver</u>	MOTHER FULL MAIDEN NAME <u>Mable A. Fieath</u> RESIDENCE <u>St. Maries Ida</u> COLOR <u>White</u> AGE AT LAST BIRTHDAY _____ (Years) BIRTHPLACE <u>Long Island</u> OCCUPATION <u>housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 3:00 P M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1924

(Signature) C. J. Kinsaling M.D.
Physician or midwife
Address St. Maries Ida
Filed May 8 1924 Bohmer
Registrar. Registrar.

NOTED BY THE REGISTRAR THAT THE CHILD WAS BORN WITH A BIRTH DEFECT AND THAT THE DEFECT WAS NOT CORRECTED BY THE SURGEON GENERAL'S OFFICE.

PLACE OF BIRTH

STATE OF IOWA
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

2
120868

CERTIFICATE OF BIRTH

No. _____
County of _____
City of _____
Hospital _____
Registration District No. _____
Local Registrar's No. _____

Full Name of Child _____
Sex of Child _____
Date of Birth _____
Time of Birth _____
Place of Birth _____
Weight at Birth _____
Length at Birth _____
Circumference at Birth _____
Color at Birth _____
Birthplace _____
Occupation _____

What antiseptical solution was used to clean the child? _____
Name of Physician _____
Name of Midwife _____
Name of Father _____
Name of Mother _____
Color _____
Age at Last Birthday _____
Birthplace _____
Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.
I hereby certify that I attended the birth of this child who was _____ at _____
(Signature) _____
Address _____
Filed _____
Registrar _____

When there was no attending physician or midwife then the father, householder, etc. should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. (Give names added from a supplemental report.)

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Benewah*City of *St. Marys*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Pauline Alice Fiedler

CERTIFICATE OF DEATH

Registration District No. *32*Registration District No. *2049*(No. *2049*)

(St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. *15951*Local Registrar's No. *21*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Female white*

(Write the word)

6. DATE OF BIRTH

Apr. 5 1924
(Month) (Day) (Year)

7. AGE

*Stillborn*IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

*St. Marys, Ida*10. NAME OF
Father*Gus W. Fiedler*11. BIRTHPLACE
OF FATHER

(State or Country)

*Iowa*12. MAIDEN NAME
OF MOTHER*Mabel A. Filseth*13. BIRTHPLACE
OF MOTHER

(State or Country)

Troy, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Gus W. Fiedler

(Address)

St. Marys, Ida

15.

Filed *Apr 5 1924**1924**Bellevue*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr. 5 1924
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Apr. 5 1924 to *April 5 1924*
that I last saw *Stillborn* *April 5 1924*
and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

*Not known**Stillborn*

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*C. H. Hunsolving M. D.**Apr. 5 1924* (Address) *St. Marys, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place of death.....yrs.....mos.....days, State.....yrs.....mos.....ds.
In the
Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

Apr. 6 1924

20. UNDERTAKER

Mitchell & Mearns

ADDRESS

St. Marys, Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

PLACE OF BIRTH

285-210 2006 = 653

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Bingham

City of Springfield

No. _____ St. _____ Registration District No. _____ State File No. S 120917

Hospital _____ Primary _____ District No. 116 Local Registrar's No. 838

FULL NAME OF CHILD

Lilace Shelman

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin <u>Twins</u> and <u>2</u> in order of birth (To be answered only in event of plural births)	Legitimate? <u>Yes</u>	Date of birth <u>Apr 10</u> 192 <u>2</u> (Month) (Day) (Year)
----------------------------	---	------------------------	--

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 3

Number of child of this mother now living, including present birth 2

FATHER
FULL NAME Don Shelman
RESIDENCE Springfield, Ida
COLOR White AGE AT LAST BIRTHDAY 31 (Years)
BIRTHPLACE Kansas
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Myrtle Jeanette Wells
RESIDENCE Springfield, Ida
COLOR White AGE AT LAST BIRTHDAY 29 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 11 P.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) M. C. MacKinnon MD
Physician
(Physician or midwife)

Address Abandon, Ida

Filed Apr 10 1922 M. C. MacKinnon

Registrar.

Registrar.

PLACE OF BIRTH

City of
County of

to not
bldo

100-443887-100

Date: _____
 Birth: _____
 (1900)

FLYING NAME OF CHIEF

Hospital.....
Primary Referral Physician.....
Local Hospital's No.....

No. _____ Registration District No. _____ State of _____

CERTIFICATE OF BIRTH

BOARD OF STATE STAFFERS

DEATH NO STATE

CERTIFICATE OF ADOPTING PHYSICIAN OR MIDWIFE

On the date above stated, I hereby certify that

life after death. A stillborn child is one that neither cries nor shows other evidence of being alive. When there was no attending physician or midwife, then the father himself would see and make the report. A stillborn child is one that neither cries nor shows other evidence of being alive. When there was no attending physician or midwife, then the father himself would see and make the report.

(Give names added from a supplemental report)

Physician's Office

(9111812)

291.

• 742186248H

751347

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham
City of Springfield

Registration District No. 116

Primary Registration District No. 2193

File No. 20205

Registered No. 88

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lilac

Wells Shelman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White

Single
(Write the word.)

6. DATE OF BIRTH

ap 10

924

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Don Shelman

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Myrtle Jeonette Wells

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Don Shelman

(Address)

Abertown Id

15.

Filed

ap 10

19

McMurtre

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

ap 10

(Month)

(Day)

24
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw h. alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still born
Remature twin birth
32nd week

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. C. McMurtre M. D.

19 (Address) Abertown Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Springfield Id

ap 11 1924

20. UNDERTAKER

McMurtre

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

655-1171014-319

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

MAY 6 1924

CERTIFICATE OF BIRTH

Form V. S. No. 11-G-25m-7-21-19

S
121009

County of Canyon

City of ampa

Registration District No. 7

File No. 2

No. _____ St.

Primary Registration District No. 1886

Registered No. _____

Hospital Mercy

Stillborn

Weeks

FULL NAME OF CHILD

Sex of Child <u>male</u>	Twins Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of Birth <u>3</u> <u>17</u> <u>1924</u> (Month) (Day) (Year)
--------------------------	--	-----	---	---------------------------	---

FULL NAME <u>R. H. Weeks.</u>	FATHER
RESIDENCE <u>ampa, Idaho.</u>	
COLOR <u>white.</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)
BIRTHPLACE <u>Utah.</u>	
OCCUPATION <u>Dentist</u>	

FULL MAIDEN NAME <u>June Carson.</u>	MOTHER
RESIDENCE <u>ampa, Idaho.</u>	
COLOR <u>white.</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)
BIRTHPLACE <u>Utah.</u>	
OCCUPATION <u>House wife.</u>	

WHAT BACTERICIDAL SOLUTION WAS USED IN CASE OF
Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn, at _____ M.
(Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Geo. J. D. [illegible]
Physician
(Physician or midwife)

Given names added from a supplemental report.

Address _____
Filed April 22 1924 Pearle Dodds
Registrar

Registrar

2
T-
0
0
0

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho MAY 15 1924

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth (CITY Nampa FILE NO. 121009
(ST. DATE OF BIRTH March 17
(COUNTY Canyon SEX OF CHILD Male

FATHER Dr. J. H. Weeks

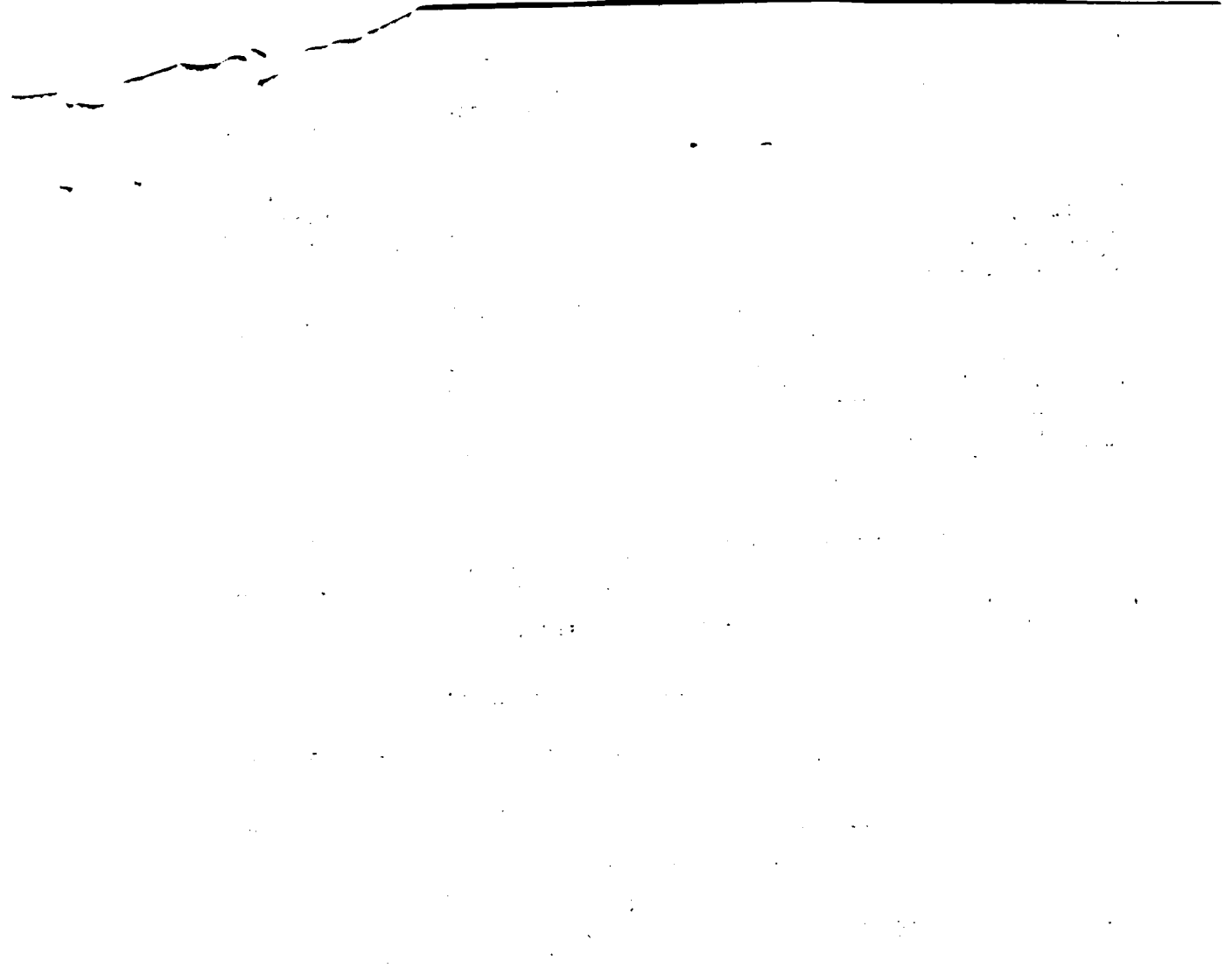
MOTHER

Myrtle June Larsen
(MAIDEN NAME)
was not

I HEREBY CERTIFY that the child herein described ~~has been~~ named:

As the baby was stillborn, we did not
pick out a name for it.

Dr. J. H. Weeks
Signature of Father or Mother.



THIS IS A PERMANENT RECORD
AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

1. PLACE OF DEATH

County of Canyon
City of Manpa

If death occurs away from
usual residence, give facts
called for under special in-
formation.

RECEIVED
1924
VITAL
REGISTRATION DISTRICT NO. 1806

CERTIFICATE OF DEATH

Registration District No. 7
Primary Registration District No. 1806
(No. 1806 St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 45343
Local Registrar's No. _____

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME

Baby Boy
Mott Christensen Weeks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male White (Write the word)

6. DATE OF BIRTH

March 17 1924
(Month) (Day) (Year)

7. AGE

Stillbirth IF LESS than 1
day how many
hrs. or
Yrs. Mos. ds. min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
Father

11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER

13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed April 22 1924 Pearl Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 17 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
3-17-1924 to 3-17-1924,
that I last saw him alive on Still born - 3-17-1924,
and that death occurred on the date stated above, at Not known M.

The CAUSE OF DEATH* was as follows:

Still born. Death in all
probability occurred at least
3 weeks previous.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory undetermined
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Geo. W. Kelly, M. D.

19 (Address) Manpa, Idaho

*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place _____ In the
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted
if not at place of death?

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Manpa March 19 1924

20. UNDERTAKER

None ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

764-121-016-2543
PLACE OF BIRTH

RECEIVED
MAY 18 1924
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Cassia
City of Burley

CERTIFICATE OF BIRTH 121108

No. _____ St. _____ Registration District No. 117 File No. _____

Hospital _____ Primary Registration District No. 2196 Registered No. 2819

FULL NAME OF CHILD Stillborn Gould
(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other? _____ { and } Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>4-21</u> 192 <u>4</u> (Month) (Day) (Year)
-----------------------	---	------------------------	--

What bactericidal solution was used in eyes? Silver Nitrate

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 5

FATHER		MOTHER	
FULL NAME	<u>G. A. Gould</u>	FULL MAIDEN NAME	<u>Mary G. Hicks</u>
RESIDENCE	<u>Burley, Ida.</u>	RESIDENCE	<u>Burley</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>37</u> (Years)	AGE AT LAST BIRTHDAY	<u>29</u> (Years)
BIRTHPLACE	<u>Utah</u>	BIRTHPLACE	<u>Utah</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at Burley on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. J. C. Patterson
Physician
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address Burley, Ida.
Filed 5-1 1924 Dr. J. C. Patterson
Registrar.

6

1. 1. 1.

1. 1. 1.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

MAY 13 1924
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of CassiaCity of Burley, P.F.D.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn Gould

BUREAU OF VITAL STATISTICS

Registration District No. 117Primary Registration District No. 2196

No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 45358Registered No. 705

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Apr 21 1924
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Burley, Ida. P.F.D.

10. NAME OF FATHER

G. A. Gould

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Mary G. Hicks

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. A. Gould(Address) Burley, Ida. P.F.D.

15.

Filed 4-22 1924 Wm Patterson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 21 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw h. alive on 19

and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH was as follows:

Stillborn probably due to injury to mother.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. C. Patterson M. D.
4-21-1924 (Address) Burley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley, Ida.

DATE OF BURIAL

4-21-1924

20. UNDERTAKER

None

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

155-229,021-693 RECEIVED
PLACE OF BIRTH
County of Franklin
City of Preston, Idaho.
No. 121155 Registration District No. 27 State File No. 121155
Hospital St. ... Primary Registration District No. 2119 Local Registrar's No. 87
FULL NAME OF CHILD Willie
(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? and { Number in order of birth Legiti- mate? Yes Date of birth April 29, 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth <u>1</u>		Number of child of this mother now living, including present birth <u>----</u>	
FULL NAME FATHER <u>Samuel Jenkins</u>		FULL MAIDEN NAME MOTHER <u>Florence Wilmore</u>	
RESIDENCE <u>Preston, Idaho.</u>		RESIDENCE <u>Preston, Idaho.</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>18</u> (Years)
BIRTHPLACE <u>Fairview, Idaho.</u>		BIRTHPLACE <u>Rexburg, Idaho.</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Born dead at 6 months
on the date above stated. Stillborn at 6. A. M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.
 , 1924

(Signature) E. W. Slater

Physician.

(Physician or midwife)

Address Preston, Idaho.

Filed 5-7 1924

Registrar.

Registrar.

Boise, Idaho

MAY 1 5 1924

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

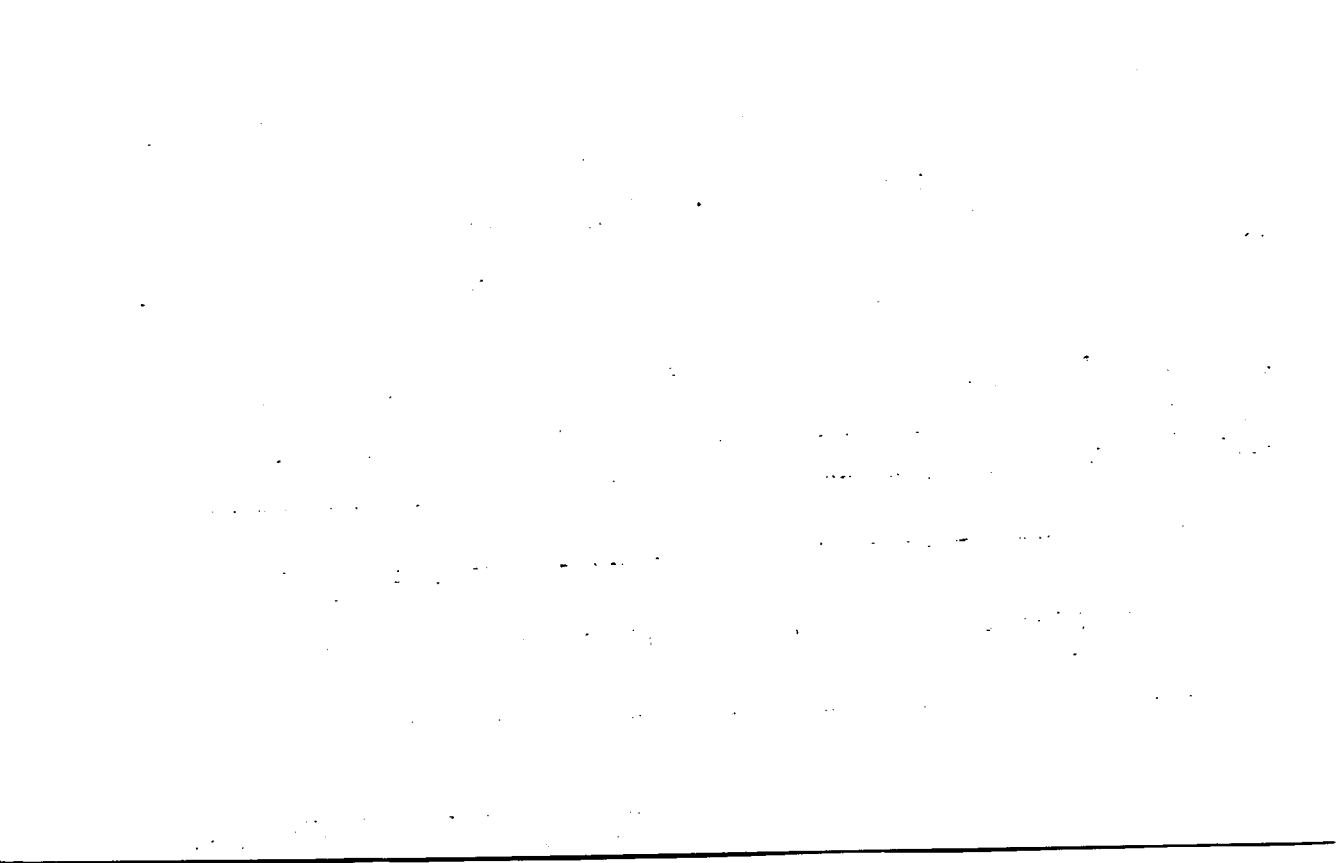
* * * * *

Place of Birth (CITY Boise FILE NO. 121155
 (ST. Idaho DATE OF BIRTH April 9
 (COUNTY Blaine SEX OF CHILD Female
 FATHER Samuel J. ... MOTHER Helen ...
 (MAIDEN NAME)

I HEREBY CERTIFY that the child herein described has been named:

Baby ...

Signature of Father or Mother.



FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Franklin*
City of *Preston*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. *27*
Primary Registration District No. *2/19*Child *Samuel Jenkins* (St.)*No name*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *46698*Registered No. *38*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Apr 29 - 1924
(Month) (Day) (Year)

7. AGE

newborn
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Preston Idaho

10. NAME OF FATHER

Samuel Jenkins

11. BIRTHPLACE OF FATHER

(State or Country)

Preston Idaho

12. MAIDEN NAME OF MOTHER

Florence Wilmore

13. BIRTHPLACE OF MOTHER

(State or Country)

Rexburg Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

S. G. Jenkins
Preston Idaho

15.

Filed *June 10 1924**A. B. Smith*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 29 - 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 29 - 1924 to *April 29 1924*
that I last saw him alive on *April 29 1924*
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

This child was dead at birth - had been dead for some days.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

premature birth

(Duration) Yrs. mos. ds.

(Signed)

G. W. States M. D.*May 1 1924* (Address) *Preston Idaho*

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19.

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

299-123.023-412

PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C—25m-9-8-15

CERTIFICATE OF BIRTH

S121204

County of BenCity of EmmettRegistration District No. 6

File No. _____

No. _____ St. _____

Primary Registration District No. _____

Registered No. _____

Hospital _____

FULL NAME OF CHILD Stell Earn

Sex of Child

MaleTwin
Triplet
or other?{ and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?yesDate of
Birth3-23 1914
(Month) (Day) (Year)FULL
NAMEFATHER
Arthur R KirkFULL
MAIDEN
NAME

MOTHER

Estes Salella Dakin

RESIDENCE

Emmett Ida

RESIDENCE

Emmett Ida

COLOR

WhiteAGE AT LAST
BIRTHDAY25
(Years)

COLOR

WhiteAGE AT LAST
BIRTHDAY25
(Years)

BIRTHPLACE

Canada

BIRTHPLACE

Oregon

OCCUPATION

Farmer

OCCUPATION

House wifeNumber of child of this mother, including present birth 2Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE *

I hereby certify that I attended the birth of this child, who was Stell Earn, at 7 P M.
on the date above stated. (Born alive or stillborn)

(Signature)

J. Reynolds

(Physician or midwife)

Given names added from a supplemental report.

19. _____

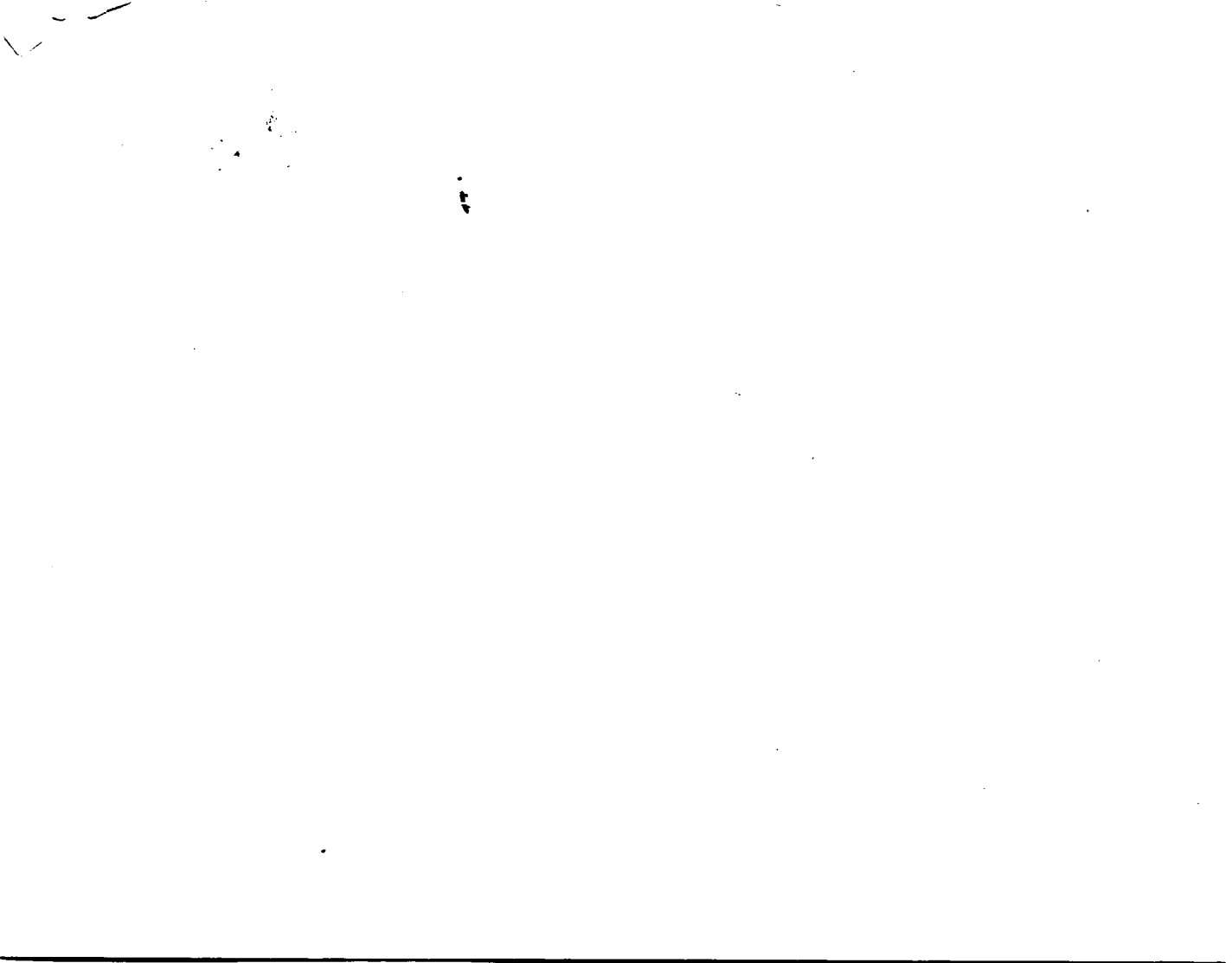
Address

Emmett

Filed

4-24 1914J. Reynolds

Registrar



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

457-115-023-299
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

121223

County of Ben

City of Emmett

No. _____ St. _____

Hospital _____

Registration District No. 6

File No. _____

Primary Registration District No. _____

Registered No. _____

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>3</u> <u>15</u> <u>1924</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------	-----------------------------	---

What bacteriocidal solution was used in eyes? 1% aq no 3

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME David R. DeGraw
RESIDENCE Emmett Ida
COLOR white AGE AT LAST BIRTHDAY 27 (Years)
BIRTHPLACE Johnson Utah
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Loris Kirk
RESIDENCE Emmett Ida
COLOR white AGE AT LAST BIRTHDAY 26 (Years)
BIRTHPLACE Yorkshire England
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born at 8:05 a M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) R. N. Cunningham

(Physician or midwife)

Give names added from a supplemental report.

Address Physician

Filed 4-12 1924 J. B. Reynolds

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

695-119.024-962
PLACE OF BIRTH

RECEIVED

BUREAU OF VITAL STATISTICS

WELFARE

S

County of Gordonia MAY 5 1924
City of Gordonia BUREAU OF VITAL STATISTICS
No. _____ St. Registration District No. 24 File No. 121234
Hospital Gordonia Primary Registration District No. _____ Registered No. _____

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>April 19</u> 192 <u>4</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth... 4 Number of child of this mother now living, including present birth... 3

FATHER		MOTHER	
FULL NAME <u>Herman Wienick</u>	FULL MAIDEN NAME <u>Angatha Roemer</u>		
RESIDENCE <u>Gordonia G.</u>	RESIDENCE <u>Gordonia G.</u>		
COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>43</u> (Years)	COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>36</u> (Years)		
BIRTHPLACE <u>Minneapolis</u>	BIRTHPLACE <u>Minneapolis</u>		
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 3:30 A. M.
on the date above stated. (Born alive or stillborn)

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. E. Claub

(Physician or midwife)

Give names added from a supplemental report.

Address Gordonia Idaho

Filed 5-3-1924 J. E. Claub

Registrar.

Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

562-227-025-396
PLACE OF BIRTH

RECEIVED
MAY 8 1924

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Idaho
City of Whitebird
No. _____ St. _____
Registration District No. 103 File No. 12-238
Hospital _____ Primary Registration District No. 2181 Registered No. 135
FULL NAME OF CHILD Lois Eileen Vosburgh
(Certificate of no value without full name of child.)

Sex of Child <u>7</u>	Twin Triplet or other? <u> </u> and <u> </u> Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>April 27</u> 192 <u>4</u> (Month) (Day) (Year)
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What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER	MOTHER
FULL NAME <u>Robert H Vosburgh</u>	FULL MAIDEN NAME <u>Ruth Crooks</u>
RESIDENCE <u>Whitebird Ida</u>	RESIDENCE <u>Whitebird Ida</u>
COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>23</u> (Years)	COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>19</u> (Years)
BIRTHPLACE <u>Wash.</u>	BIRTHPLACE <u>Idaho</u>
OCCUPATION <u>Laborer</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born at 9:00 a. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) G S Stockton
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Address Grangeville Ida
Filed May 1 1924 G S Stockton
Registrar.

Registrar.

Registrar.

8

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Idaho
City of Grangeville

If death occurs away from usual residence, give facts called for under special information.

RECEIVED CERTIFICATE OF DEATH

Registration District No. 103Primary Registration District No. 2181

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 45401Registered No. 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Iris Eileen Vosburgh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

7

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

April 27 1924
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Whitebird Idaho

10. NAME OF FATHER

Robert N Vosburgh

11. BIRTHPLACE OF FATHER

(State or Country)

Wash

12. MAIDEN NAME OF MOTHER

Ruth Crooks

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robert N Vosburgh

(Address)

Whitebird Idaho

15.

Filed

May 1 1924 G S Stickler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 27 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw h. alive on 19

and that death occurred on the date stated above, at N

The CAUSE OF DEATH* was as follows:

Still born - destroyed during birth,
(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

G S Stickler M. D.

4/27/1924 (Address) Grangeville Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Whitebird Idaho4/28 1924

20. UNDERTAKER

ADDRESS

none

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

162-111-026-751
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Jefferson

City of Trinidad

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. _____ State File No. 121283

Hospital _____ Primary Registration District No. _____ Local Registrar's No. 295

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>Boy</u>	Twin Triplet or other? <input checked="" type="checkbox"/>	and	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>Feb. 11</u> , 192 <u>4</u> (Month) (Day) (Year)
-------------------------	--	-----	-----------------------------------	------------------------	---

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth _____ Number of child of this mother now living, including present birth 0

FULL NAME <u>ROY E. JOHNSON</u>	FATHER	FULL NAME <u>Margaret Pearson</u>	MOTHER
RESIDENCE <u>Trinidad, Idaho</u>		RESIDENCE <u>Trinidad, Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>35</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)
BIRTHPLACE <u>Utah</u>		BIRTHPLACE <u>Iowa</u>	
OCCUPATION <u>miner</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive Stillborn at Trinidad on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Sam F. Price

(Physician or midwife) Thos. J. Price

Address Trinidad, Idaho

Filed Apr 10, 1924 Ray H. Fisher

Registrar.

Registrar.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

APR 2

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Jefferson
City of Perth

Registration District No. 28
Primary Registration District No. 2176
(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 45366
Registered No. 53

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH Feb 11 1924
(Month) (Day) (Year)

7. AGE Infant IF LESS than 1 day how many hrs. or min.?
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Roy E. Joslin

11. BIRTHPLACE OF FATHER Neb
(State or Country)

12. MAIDEN NAME OF MOTHER Margie M Pearson

13. BIRTHPLACE OF MOTHER Iowa
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy E. Joslin
(Address) Perth, Ida

15. Filed Apr 10 1924 Ray Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 11 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....
that I last saw h..... alive on 19.....
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Stillborn
(Duration) Yrs. mos. ds.
Contributory.....
(Secondary)
(Duration) yrs. mos. ds.
(Signed) Samuel Price M. D.
Feb 24 1924 (Address) Perth Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Perth DATE OF BURIAL Feb 20 1924

20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

57
24165-2091-027-244
PLACE OF BIRTH

Form V. S. No. 11-C--25m-7-21-19

STATE OF IDAHO
BUREAU OF VITAL STATISTICSCounty of Franklin MALE CERTIFICATE OF BIRTH

S121337

City of Boyleston Registration District No. 23

File No. _____

No. _____ St. 1017Primary Registration District No. 2017

Registered No. _____

Hospital _____

FULL NAME OF CHILD Leola James

Sex of Child <u>7</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate? <u>Yes</u>	Date of Birth <u>Nov 9</u> 19 <u>24</u> (Month) (Day) (Year)
-----------------------	---	-----	--------------------------------	-------------------------------	---

FULL NAME <u>Byron James</u>	FATHER
RESIDENCE <u>Hawaii, Ida</u>	
COLOR <u>Wh.</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)
BIRTHPLACE <u>Utah</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Edith Bull</u>	MOTHER
RESIDENCE <u>Hawaii, Ida</u>	
COLOR <u>Wh.</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 11 A M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. Barry M.D.

(Physician or midwife)

Given names added from a supplemental report.

19

Address BoylestonFiled Apr 29 1924

Registrar

Registrar C. D. P. Per M.D.

2

1000000

1000000

1

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

141-2191028-432
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

121361

County of Rootenai
City of Spirit Lake
No. 45
Hospital Spirit Lake Hospital
Primary Registration District No. 45

File No. _____
Registered No. _____

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Feb 19</u> 192 <u>4</u> (Month) (Day) (Year)
----------------------------	------------------------------	-----------	--------------------------------	------------------------	--

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Carl Adams
RESIDENCE Spirit Lake, Idaho
COLOR white AGE AT LAST BIRTHDAY 24 (Years)
BIRTHPLACE S. Dakota
OCCUPATION Acetylene Welder

MOTHER
FULL MAIDEN NAME Beatrice Mary McShyne
RESIDENCE Spirit Lake Idaho
COLOR white AGE AT LAST BIRTHDAY 19 (Years)
BIRTHPLACE N. Y.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 10:02 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) R. G. Gillson, M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address _____

Filed 4/25 1924 S. H. H. H. H.

Registrar.

Registrar.

595-127-028-912
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

County of Hortons
City of 6-10 A
No. 719 W. Garden St. Registration District No. 30 State File No. 121401
Hospital 6-10 A Primary Registration District No. 1057 Local Registrar's No. 1760
FULL NAME OF CHILD Ludwig Nielsen
(Certificate of no value without full name of child)

Sex of Child M. Twin Triplet or other? } and { Number in order of birth 1st Legitimate? yes Date of birth 4 27 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Argyrol
Number of child of this mother, including present birth 1st Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Richard Nielsen
RESIDENCE 719 W. Garden
COLOR white AGE AT LAST BIRTHDAY 24 (Years)
BIRTHPLACE Withee Wis
OCCUPATION Meltman

MOTHER
FULL MAIDEN NAME Herdis Rasmussen
RESIDENCE 719 W. Garden
COLOR white AGE AT LAST BIRTHDAY 23 (Years)
BIRTHPLACE Superior Wis
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at 2 P. M. on the date above stated.

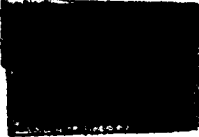
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) Do J. Nord.
(Physician or midwife)

Address Corn d Alan
Filed 5-5 192 4

Registarr. 192
Registarr. D. D. D.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



FORM V, S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Boonville
City of Corvus, Ala.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ludwig Nielsen

CERTIFICATE OF DEATH

Registration District No. 30Registration District 1057(No.) Corvus-Alene Hospital (St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 43436Registered No. 1363

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

April
(Month)27
(Day)1924
(Year)

7. AGE

Yrs.

Mos.

0 ds.IF LESS than 1 day
how many..... hrs.
or 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Richard Nielsen

11. BIRTHPLACE OF FATHER

(State, or Country)

Wisconsin

12. MAIDEN NAME OF MOTHER

Berdis Rasmussen

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard P. Nielsen(Address) 719 W. Garden - Corvus, Ala.

15.

Filed 5-5-1924D. D. Dreman

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April
(Month)27
(Day)1924
(Year)

17. I HEREBY CERTIFY: That I attended deceased from

April 271924

to

April 271924

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia and premature detachment of placenta.Stillborn

(Duration)

Yrs.

mos.

2 ds.Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

John M. Wood M. D.April 271924

(Address)

Corvus, Ala.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Low Cemetery

DATE OF BURIAL

4/28/1924

20. UNDERTAKER

E. L. Cassidy

ADDRESS

Corvus, Ala.

JAN 20 2004

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. E.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

239-108031-468
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

MAY 10 1924

BUREAU OF VITAL STATISTICS

S

County of Lewis

City of Nezperce

No. _____ St. _____

Registration District No. 109

State File No. 121451

Hospital _____

Primary Registration District No. 242

Local Registrar's No. _____

FULL NAME OF CHILD Baby Sleighter

(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>4-8-1924</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1

Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Luis Sleighter
RESIDENCE Nezperce, St. Paul
COLOR white AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Idaho
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Anna Weaher
RESIDENCE Nezperce, Paul
COLOR white AGE AT LAST BIRTHDAY 31 (Years)
BIRTHPLACE Idaho
OCCUPATION House

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 9 9 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) C. P. Bryan

(Physician or midwife)

Give names added from a supplemental report.

Address Idaho

Filed 4/10 1924

1924

C. J. Johnson
Registrar.

Registrar.

8

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

213-185-022-466
PLACE OF BIRTH

County of Fremont
City of Parber

STATE OF IDAHO
DEPARTMENT OF PUBLIC
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

No. St. Registration District No. 100 State File No. 121491
Hospital Primary Registration District No. 2178 Local Registrar's No. 763

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child male { Twin Triplet or other? } and { Number in order of birth } Legitimate? yes Date of birth 4 5 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 14 Number of child of this mother now living, including present birth 11

FATHER
FULL NAME Thomas Ball
RESIDENCE Parber, St Anthony Route #3
COLOR white AGE AT LAST BIRTHDAY 57 (Years)
BIRTHPLACE England
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Sarah Emelia Powell
RESIDENCE St Anthony Route 3
COLOR white AGE AT LAST BIRTHDAY 46 (Years)
BIRTHPLACE Missouri
OCCUPATION house-wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

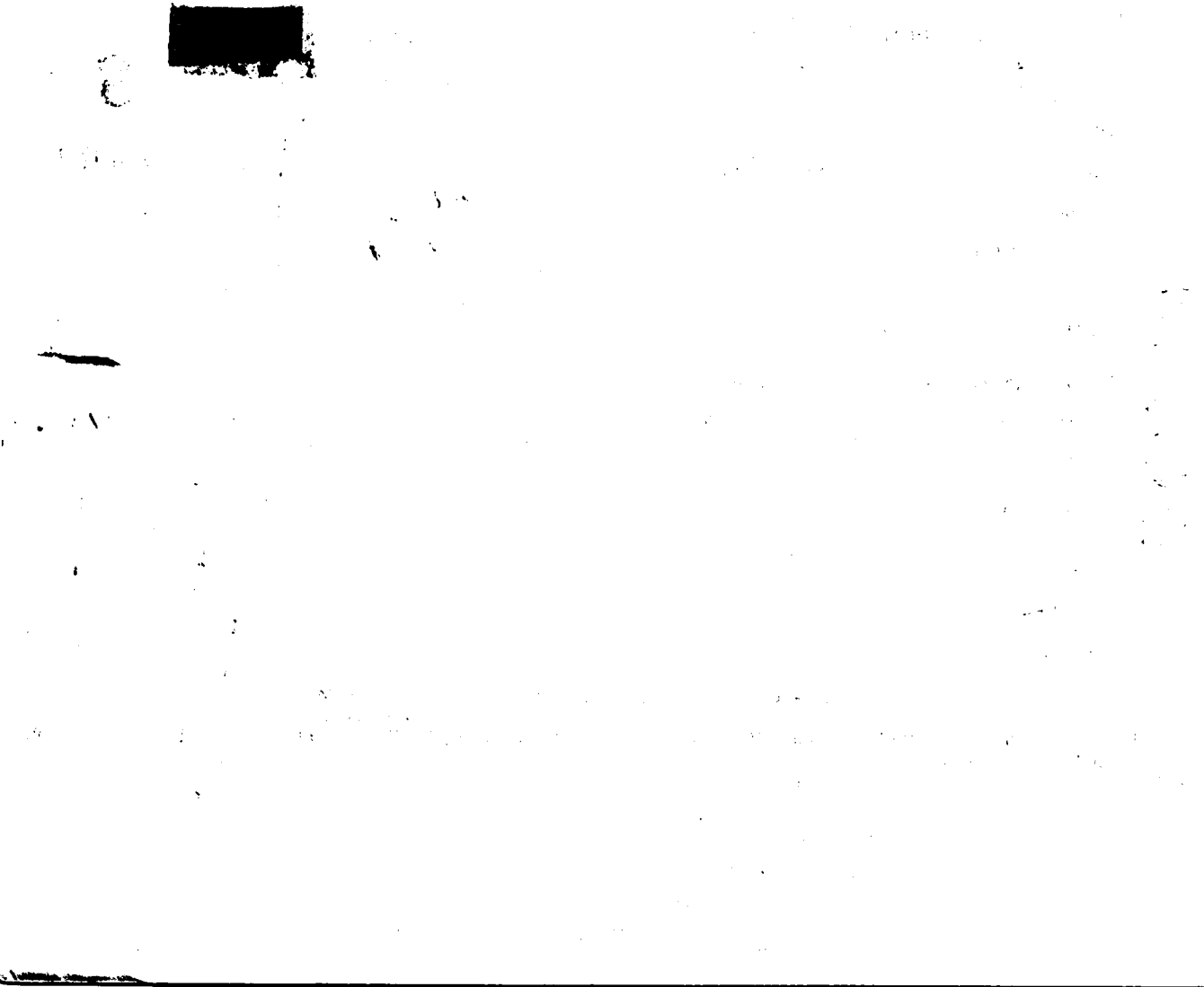
I hereby certify that I attended the birth of this child, who was { Born alive } at 11:55 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) A. Rutherford
(Physician or midwife)

Address Perburg, Ida
Filed 71 192 4
Registrar. Registrar.



55-122-038-553

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

County of PayetteCity of PayetteRegistration District No. 4File No. 121551

No. _____ St. _____

Primary Registration District No. 1008.Registered No. 18.

Hospital _____

FULL NAME OF CHILD

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legitimacy? <u>No</u>	Date of Birth <u>March 22</u> <u>19</u> <u>24</u> (Month) (Day) (Year)
--------------------------	---	-----	---	-----------------------	---

FULL NAME FATHER
Roy VanderfordFULL MAIDEN NAME MOTHER
Julia Nelson.RESIDENCE Payette, Idaho.RESIDENCE Payette, Idaho .COLOR White AGE AT LAST BIRTHDAY 24
(Years)COLOR White AGE AT LAST BIRTHDAY 19
(Years)

BIRTHPLACE

BIRTHPLACE Cove, Oregon.OCCUPATION ClerkOCCUPATION General Labor.Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn, at 1.00 P M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Physician.

(Physician or midwife)

Given names added from a supplemental report.

19

Address Payette, IdahoFiled March 22 19 24

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

2

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

351-121-542-913
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Twin Falls
City of Kimberly, Ida

CERTIFICATE OF BIRTH 121606

No. _____ St. Registration District No. 36 State File No. _____

Hospital _____ Primary Registration District No. _____ Local Registrar's No. 26

FULL NAME OF CHILD not named

(Certificate of no value without full name of child)

Sex of Child	<u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>Mar 21</u> 192 <u>4</u>
					(Month) (Day) (Year)

What bactericidal solution was used in eyes? Neo S.

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME J. H. Clark

RESIDENCE
Kimberly, Ida

COLOR White AGE AT LAST BIRTHDAY 26 (Years)

BIRTHPLACE
West. Va.

OCCUPATION
farmer

MOTHER
FULL MAIDEN NAME Gladys Dalley

RESIDENCE
Kimberly, Ida

COLOR White AGE AT LAST BIRTHDAY 24 (Years)

BIRTHPLACE
Wyo.

OCCUPATION
Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive { Stillborn } at 7 a.m. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) M. W. Davis

Physician

(Physician or midwife)

Address Kimberly, Idaho

Filed Mar 28 192 4 M. W. Davis

Registrar.

Registrar.

1. 1. 1.

1. 1. 1.

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1. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

 1. PLACE OF DEATH. **RECEIVED**
Registration District No. 36
County of Tam. Falls **APR 24 1924**
City of Kimberly **PR.** St.)
If death occurs away from usual residence, give facts called for under special information.

 File No. 45509
Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED, OR DIVORCED. (Write the word.)

6. DATE OF BIRTH

Mar - 21 1924
(Month) (Day) (Year)

7. AGE

0
yrs. mos. da.

 IF LESS than 1 day
how many hrs. or
mins.

8. OCCUPATION

 (a) Trade, profession or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

J. H. Clark

11. BIRTHPLACE OF FATHER

(State or Country) West. Va.

12. MAIDEN NAME OF MOTHER

Gladys Dalley

13. BIRTHPLACE OF MOTHER

(State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss J. H. Clark(Address) Kimberly Idaho

15.

 Filed Mar - 22 1924 J. H. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar - 21 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,
that I last saw h. alive on 191,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

StillbornPeriod of Gestation 9 months

(Duration) yrs. mos. da.

Contributory no demonstrably(Secondary) reason

(Duration) yrs. mos. da.

(Signed) J. H. Davis M. D.9/21 1924 (Address) Kimberly Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Home Mar 22 1924

20. UNDERTAKER

ADDRESS

Home

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

APR 23 1924

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

21610

County of Valley

City of 4 miles east of

No. 236-112083-385 St.

Registration District No. 15

State File No. _____

Hospital _____ Primary Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD Rogers Stockham (Stillbirth)
(Certificate of no value without full name of child)

Sex of Child male { Twin Triplet or other? } and { Number in order of birth } Legitimate? Yes Date of birth March 12 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Hyman Lowell Stockham</u>	<u>Arling, Idaho</u>	<u>Elsie Ruth Lynch</u>	<u>Arling, Idaho</u>
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>19</u> (Years)
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Kansas</u>	
OCCUPATION <u>mechanic</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE:

I hereby certify that I attended the birth of this child, who was Stillborn at 5:20 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) J. F. Rutledge, M.D.

(Physician or midwife)

Address Casper, Wyo.

Filed 4-1- 1924 Stella Cain

Stella Cain
Deputy Registrar.

Deputy Registrar.

36



MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Valley

City of 4 miles east of

If death occurs away from usual residence, give full address called for under special information.

CERTIFICATE OF DEATH

Registration District No. 15

Primary Registration District No. 15

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 45529

Local Registrar's No. 1529

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rogers Stockham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH March 12 1924
(Month) (Day) (Year)

7. AGE 6 mos in utero IF LESS than 1 day how many hrs. or min.?
Yrs. Mos. ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business or establishment, in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Hyman Howell Stockham

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Elsie Ruth Lynch

13. BIRTHPLACE OF MOTHER Kansas
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. F. Rutledge, M.D.
(Address) Cascade Idaho

15. Filed 19 Little Cairn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 12 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12 1924 to March 12 1924,
that I last saw him alive on 12,
and that death occurred on the date stated above, at 5:20 PM.
The CAUSE OF DEATH* was as follows:

Placental Cord-Torsion delivery
Stillbirth
(Duration) yrs. mos. ds.
Contributory (Secondary) maternal
(Duration) yrs. mos. ds.
(Signed) J. F. Rutledge M. D.
(Address) Cascade

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

992- PLAC

2591844

County of *Madison*

City of *Madison*

No. St.

Registering No. *87*

State File No.

Hospital

Primary Registration District No. *2154*

Local Registrar's No. *4*

FULL NAME OF CHILD *John S. Ristved*

(Certificate of no value without full name of child)

Sex of Child *Female*

Twin Triplet or other? *No*

and { Number in order of birth

Legitimate? *yes*

Date of birth *April 9 - 1928*

(Month) (Day) (Year)

What bactericidal solution was used in eyes? *no*

Number of child of this mother, including present birth *5*

Number of child of this mother now living, including present birth *3*

FULL NAME FATHER *John S. Ristved*

RESIDENCE *Madison Idaho*

COLOR *White*

AGE AT LAST BIRTHDAY *46*

(Years)

BIRTHPLACE *North Dakota*

OCCUPATION *Farmer*

FULL MAIDEN NAME MOTHER *Ethel M. Wilson*

RESIDENCE *Madison Idaho*

COLOR *White*

AGE AT LAST BIRTHDAY *37*

(Years)

BIRTHPLACE *Idaho*

OCCUPATION *Housewife*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *Stillborn* at *12:30 P.* M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

1928 *4*

(Signature) *F. Schreyer*

(Physician or midwife)

Address *Madison Idaho*

Filed *Feb 16 1924*

Registrar.

Registrar.



6

1. PLACE OF DEATH

County of *Washington*
City of *Medvale*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Baby Ruth*STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. *45532*Local Registrar's No. *2*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Female White**single*
(Write the word)

6. DATE OF BIRTH

April 9 1924
(Month) (Day) (Year)

7. AGE

still born
Yrs. Mos. ds.IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Medvale Id

10. NAME OF FATHER

John O Keith

11. BIRTHPLACE OF FATHER

(State or Country)

W D.

12. MAIDEN NAME OF MOTHER

Ethyl Wilson

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

F. Schumacher
Warren

15.

Filed

*Apr 10*19 *24**Mrs O G Keith*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 9 1924
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
19 to 19that I last saw him alive on 19
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

*still born*Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Duration) yrs. mos. ds.

(Signed)

F. Schumacher M. D.7-9-24 (Address) *Warren*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Apr 10 1924

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

913-115 '00-395
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Ada

City of _____

No. R. F. D No. 4 St. _____

Hospital _____

Registration District No. _____

CERTIFICATE OF BIRTH

File No. 121678

Primary Registration District No. 2008

Registered No. 27

FULL NAME OF CHILD

Baby Ratliff - Still Born

(Certificate of no value without full name of child.)

Sex of Child

M

Twin
Triplet
or other? -

and

Number
in order
of birth

-

Legiti-
mate?

yes

Date of
birth

May 15 1924

(Month)

(Day)

(Year)

What bacteriocidal solution was used in eyes?

none

Number of child of this mother, including present birth. 4

Number of child of this mother now living, including present birth. 2

FULL
NAME

FATHER

Jos. Ratliff

RESIDENCE

R. F. D No. 4 - Boise

COLOR

W

AGE AT LAST

BIRTHDAY

5-3

(Years)

BIRTHPLACE

Texas

OCCUPATION

Rancher

FULL
MAIDEN
NAME

MOTHER

Flora Tindall

RESIDENCE

R. F. D No. 4 - Boise

COLOR

W

AGE AT LAST

BIRTHDAY

39

(Years)

BIRTHPLACE

Penn

OCCUPATION

Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was.....
on the date above stated.

at 2 45 A. M.
(Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

B. W. Hatcher

(Physician or midwife)

Give names added from a supplemental report.

Address

317 Cleveland Bldg - Boise

Filed

May 28 1924

R. F. D No. 4

Registrar.

Registrar.

2

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS' should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

1. PLACE OF DEATH

County of Ada

City of Meridian

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 50121

Primary Registration District No. 50121

(City) Meridian (St.) Idaho

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 46389

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Single

6. DATE OF BIRTH

May 15 1924
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
hrs. or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Meridian Id.

10. NAME OF Father

Joe Rathliff

11. BIRTHPLACE OF FATHER

(State or Country) Texas

12. MAIDEN NAME OF MOTHER

Flora Tridell

13. BIRTHPLACE OF MOTHER

(State or Country) Ohio - Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Joe Rathliff
Meridian

15.

Filed May 16 1924 W. H. M.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 15 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19.

that I last saw him alive on 19.

and that death occurred on the date stated above, at 2:45 A.M.

The CAUSE OF DEATH* was as follows:

Extended head & arms -
breach presentation -
asphyxiation

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

5/15/1924 (Address) 317 Garland Ave. Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meridian 19.

20. UNDERTAKER

ADDRESS

Meridian Meridian Id.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

314-127-007-643
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

18
121783

County of Blaine **RECEIVED**
City of Hailey **JUN 6 1924**

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 57 File No. _____
Hospital _____ Primary Registration District No. 2022 Registered No. 14

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____ } and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>4 27 1924</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 4

FULL NAME FATHER
Austin A. Lambert
RESIDENCE Hailey, Ida

FULL MAIDEN NAME MOTHER
Katherine Fern Fied
RESIDENCE Hailey, Ida

COLOR white AGE AT LAST BIRTHDAY 38
(Years)

COLOR white AGE AT LAST BIRTHDAY 35
(Years)

BIRTHPLACE England

BIRTHPLACE Hailey, Ida

OCCUPATION Post Master

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 5 P M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Robert H. Wright MD

Give names added from a supplemental report.

(Physician or midwife)

Address Hailey, Ida

Filed 5-1 1924 Robert H. Wright

Registrar.

Registrar

2

1. PLACE OF DEATH

County of Blaine Registration District No. 57
 City of Hailey Primary Registration District No. 2022
 (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 45608Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant
 (Write the word.)

6. DATE OF BIRTH

4 (Month) 27 (Day) 1924 (Year)

7. AGE

IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (for employer)

Infant

9. BIRTHPLACE

(State or Country)

Hailey, Ida

10. NAME OF FATHER

Austin A. Lambert

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mathrine F. Field

13. BIRTHPLACE OF MOTHER

(State or Country)

Hailey, Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Austin A. Lambert

(Address)

Hailey, Ida

15.

Filed 5-11924R. H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4 (Month) 27 (Day) 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
 that I last saw him alive on 19
 and that death occurred on the date stated above, at 19 M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Premature - 7 mo -

(Duration) yrs. mos. ds.

(Signed)

Robert H. Wright M. D.4-28-24 (Address) Hailey, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hailey, Ida

DATE OF BURIAL

4-28-1924

20. UNDERTAKER

none

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

168-130-009-599

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

County of Banner

JUN 6 1924

CERTIFICATE OF BIRTH

121797

City of Selle, IdaNo. St. Registration District No. 75 State File No.Hospital..... Primary Registration District No. 2155 Local Registrar's No.FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin <input checked="" type="checkbox"/> Triplet <input type="checkbox"/> or other? <input type="checkbox"/>	and	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>May 30 1924</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes?

Number of child of this mother, including present birth. 4 Number of child of this mother now living, including present birth. 2

FATHER		MOTHER	
FULL NAME <u>Henry Johnson</u>	FULL MAIDEN NAME <u>Louise Erickson</u>	FULL NAME <u>Louise Erickson</u>	FULL MAIDEN NAME <u>Louise Erickson</u>
RESIDENCE <u>Selle, Ida</u>	RESIDENCE <u>Selle, Ida</u>	RESIDENCE <u>Selle, Ida</u>	RESIDENCE <u>Selle, Ida</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>37</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)
BIRTHPLACE <u>Sweden</u>	BIRTHPLACE <u>Sweden</u>	BIRTHPLACE <u>Sweden</u>	BIRTHPLACE <u>Sweden</u>
OCCUPATION <u>Rancher</u>	OCCUPATION <u>Housewife</u>	OCCUPATION <u>Housewife</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn ^{born alive} 6 month gestation ^{at} 8 A. ^{M.} on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Floyd G Wendle

(Physician or midwife)

Address Sandpoint, IdaFiled June 3 1924 Viola Allen

Registrar.

Deputy Registrar.

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

942-110-010-595

RECEIVED

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

JUN 7 1924

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S X

County of Bonner

City of Idaho Falls

Registration District No. 73

File No.

121871

No. _____ St.

Hospital L.D.L.

Primary Registration District No. 2140

Registered No.

112

FULL NAME OF CHILD Edward Russell

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legiti mate? <u>yes</u>	Date of Birth <u>5-10-24</u> (Month) (Day) (Year)
--------------------------	---	-----	---	-------------------------------	--

FULL NAME <u>Russell, Mrs Edward Jackson</u>	FATHER
RESIDENCE <u>Shelly, Ida.</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)
BIRTHPLACE <u>Iona, Idaho</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Tayson Hazel Vernon a</u>	MOTHER
RESIDENCE <u>Shelly, Ida.</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>20</u> (Years)
BIRTHPLACE <u>Goshen, Ida.</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____
on the date above stated.

Still at 10:55 P.M.
(Born alive or stillborn)

*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

H. V. Ray Hatch

(Physician or midwife)

Given names added from a supplemental report.

Address

Idaho Falls

Filed

May 23 1924

Registrar

Registrar

2

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

255-124000-851

PLACE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S X
121892

County of Conner RECEIVED
City of Idaho Falls JUN 7 1924
Registration District No. 73 File No. _____
No. _____ St. _____
Hospital LDS Primary Registration District No. 2140 Registered No. 161
FULL NAME OF CHILD Keefe Baby George Jacob

Sex of Child male Twin 1 and 1 Number in order of birth 1 Legiti mate? yes Date of Birth 4-24 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER		MOTHER	
FULL NAME	<u>Mr Lewis R. Keefe</u>	FULL MAIDEN NAME	<u>Nellie Heath</u>
RESIDENCE	<u>Idaho Falls, Ida.</u>	RESIDENCE	<u>Idaho Falls, Ida.</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>38</u> (Years)	AGE AT LAST BIRTHDAY	<u>34</u> (Years)
BIRTHPLACE	<u>Idaho Falls, Ida.</u>	BIRTHPLACE	<u>Idaho Falls, Ida.</u>
OCCUPATION	<u>Labourer</u>	OCCUPATION	<u>Housewife</u>

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 2 35 P.M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) [Signature]
(Physician or midwife)

Given names added from a supplemental report.

Address Idaho Falls, Ida.
Filed May 6 1924 [Signature] Registrar

Registrar

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

2

1915

10
(Year)

(Year)

at birth

M.

Registrar

PLACE OF BIRTH

County of

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

RECEIVED

Registration District No.

Primary Registration District No.

St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No.

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male

White

Infant
(Write the word)

6. DATE OF BIRTH

April 7th

(Month)

1924

(Day)

(Year)

7. AGE

Still born

IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF

Father

Louis A. Keefe

11. BIRTHPLACE

OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME

OF MOTHER

Nellie Heath

13. BIRTHPLACE

OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Louis A. Keefe

(Address)

Idaho Falls, Idaho

15.

Filed

Apr 29

19

2 E. Cummings

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 7th

(Month)

(Day)

1924
(Year)

17. I HEREBY CERTIFY, That I attended deceased from April 24 1924 to April 24 1924 that I last saw him alive on April 24 1924, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still born
Cause unknown
Wassermann reaction neg.

(Duration)

Yrs.

Mos.

Ds.

Contributory
(Secondary)

(Duration)

Yrs.

Mos.

Ds.

(Signed)

M. D.

19

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

4-25 1924

20. UNDERTAKER

B. B. Woodward

ADDRESS

Idaho Falls

FEB 24 1964

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

113206-016-675
PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

121953

County of Saratoga
City of Burley

RECEIVED
JUN 1

No. St. Bureau Registration District No. 117 State File No. 2858

Hospital Stilleborn Primary Registration District No. 2196 Local Registrar's No. 2858

FULL NAME OF CHILD Stilleborn
(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>May 6</u> 192 <u>4</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes? Yes Saline - 20%

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth None

FATHER
FULL NAME Joseph Jacobo
RESIDENCE Burley Ida
COLOR White AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Salt Lake City
OCCUPATION Teacher

MOTHER
FULL MAIDEN NAME Leone Ovenshaw
RESIDENCE Burley Ida
COLOR White AGE AT LAST BIRTHDAY 20 (Years)
BIRTHPLACE Rayssville Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 1:10 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) H. H. Corfer M.D.

(Physician or midwife)

Address Burley Ida

Filed 6-4 1924 W. J. C. Patterson

Registrar.

Registrar.

2.

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2.

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED

CERTIFICATE OF DEATH

45658

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No.
Registered No. 706
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Cassia Registration District No. 117
City of Burley Primary Registration District No. 2196
If death occurs away from usual residence, give facts called for under special information. No. St.)

2. FULL NAME

Baby Jacobo

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6. DATE OF BIRTH

May 6 1924
(Month) (Day) (Year)

7. AGE

Still Born

IF LESS than 1 day
how many hrs. or
..... Yrs. Mos. ds. min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Burley Ida.

10. NAME OF FATHER

Joseph Jacobs

11. BIRTHPLACE OF FATHER

(State or Country)

Salt Lake City Ut.

12. MAIDEN NAME OF MOTHER

Lena O. Peterson

13. BIRTHPLACE OF MOTHER

(State or Country)

Salt Lake City Ut.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Joseph Jacobs
Burley Ida.

15.

Filed

5-8-24

191...

D. J. Peterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 6 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

✓ 191... to ✓ 191...
that I last saw h. ✓ alive on ... 191...
and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Stillbirth Premature detachment
of Placenta
✓ (Duration) ✓ Yrs. ✓ mos. ✓ ds.

Contributory
(Secondary)

(Duration) ✓ Yrs. ✓ mos. ✓ ds.

(Signed)

G. H. Cooper

M. D.

May 6, 1924 (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days, State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rayville Ut. 6-7-24 191...

20. UNDERTAKER

ADDRESS

D. E. Johnson Burley

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

each and the number of them, in order of birth stated.

236-221-028-692
PLACE OF BIRTH

County of Kootenai
City of Conrad Idaho

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED
JUN 7 1921
CERTIFICATE OF BIRTH 127031

No. 810 Young St. Registration District No. 30 State File No. 1051
Hospital St. Luke's Primary Registration District No. 1051 Local Registrar's No. 1778
FULL NAME OF CHILD Gene Lorraine Shown

(Certificate of no value without full name of child)

Sex of Child Female Twin one and one Number in order of birth one Legitimate? yes Date of birth Apr 21 1921
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? L

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Gordon J Shown
RESIDENCE Conrad Idaho
COLOR White AGE AT LAST BIRTHDAY 21 (Years)
BIRTHPLACE Idaho
OCCUPATION mill worker

MOTHER
FULL MAIDEN NAME Anna M Fischbach
RESIDENCE Conrad Idaho
COLOR White AGE AT LAST BIRTHDAY 19 (Years)
BIRTHPLACE Washington
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive { Stillborn } at 9 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) H. H. Koedeen
Physician
(Physician or midwife)

Address Conrad Idaho

Filed 6/5 1921 A. H. Hansen

Registrar.

Registrar.

124031

State File No.

Local Registration No.

(Certificate of No. 124031 and date of birth)

(Year)

(Day)

(Month)

(Year)

and date of birth in case of

Name of child of this mother and father, including present name

Name of child of this mother and father, including present name

MOTHER

FATHER

NAME
Maiden
Name

NAME
Maiden
Name

RESIDENCE

RESIDENCE

COLOR

COLOR

AGE AT LAST
BIRTHDAY

AGE AT LAST
BIRTHDAY

ETHNICITY

ETHNICITY

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

(Signature)

I hereby certify that I attended the birth of this child, who was

(Signature of midwife)

Address

Address

101

101

Health

Large file to 124031 all days 12-20-1911 and 12-21-1911

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 30
 County of Trousdale Primary Registration District No. 1051
 City of Powerdale No. 870 Yang St.)

 File No. 43441
 Registered No. 1360

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Baby Stone

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH

April 21 1924
 (Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

 IF LESS than 1 day
 how many 0 hrs.
 or 0 min.?

8. OCCUPATION

 (a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

 (State or Country) Idaho

10. NAME OF FATHER

Gordon Stone

11. BIRTHPLACE OF FATHER

 (State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Anna Fischback

13. BIRTHPLACE OF MOTHER

 (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

 (Informant) Gordon Stone
 (Address) Powerdale

15.

 Filed 5-5-1924
S. D. Draine
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 20 1924
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

✓ 19..... to ✓ 19.....
 that I last saw h..... alive on..... 19.....
 and that death occurred on the date stated above, at..... M.
 The CAUSE OF DEATH* was as follows:

Still Born

 (Duration) 4 yrs. ✓ mos. ✓ ds.

 Contributory
 (Secondary)

 (Duration) ✓ yrs. ✓ mos. ✓ ds.

 (Signed) J. H. Naedem M. D.

4/22 1924 (Address) Powerdale

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cemetery

DATE OF BURIAL

4/22 1924

20. UNDERTAKER

P. B. Maoney

ADDRESS

Powerdale

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

de L. Jordan

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

365-228-028-396 RECEIVED
PLACE OF BIRTH

STATE OF IDAHO

JUN 7 1924 DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
BUREAU OF VITAL STATISTICS

County of Fortuna

City of C. D. C.

No. 314 Military Drive

Registration District No. 30

State File No.

122034

Hospital C. D. C.

Primary Registration District No. 105

Local Registrar's No. 1781

FULL NAME OF CHILD Patricia O. Cornell

(Certificate of no value without full name of child)

Sex of Child F

Twin
Triplet
or other?
(To be answered only in event of plural births)

and { Number
in order
of birth 1st

Legiti-
mate? yes

Date of
birth 4 28 1924

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes? Argyrol. 5%

Number of child of this mother, including present birth 1st

Number of child of this mother now living, including present birth 1st

FULL
NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY 21

(Years)

BIRTHPLACE

OCCUPATION

FULL
MAIDEN
NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY 24

(Years)

BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was { Born alive } at 4:05 P. M.
on the date above stated. { Stillborn }

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address C. D. C.

Filed 6/8 1924

Registrar.

Registrar.

data's ports in a way that does to someone with our eyes

201

shows other evidence of her first birth. It is not that mother's picture nor the other. A photograph of the mother taken the day after the birth of the child. It is not that mother's picture nor the other. A photograph of the mother taken the day after the birth of the child. It is not that mother's picture nor the other. A photograph of the mother taken the day after the birth of the child.

1. The first of these is the fact that the majority of the population of the United States is now living in urban areas. This is a result of the process of urbanization, which has been going on since the beginning of the 20th century. The population of the United States has increased from about 100 million in 1900 to over 200 million in 1960. At the same time, the population of rural areas has decreased from about 100 million in 1900 to about 50 million in 1960. This has led to a concentration of the population in urban areas, which has had a number of important consequences. One of the most important is that it has led to a change in the way of life of the majority of the population. In rural areas, the population is more closely tied to the land, and the way of life is more traditional. In urban areas, the population is more mobile, and the way of life is more modern. This has led to a number of changes in the economy, in the culture, and in the social structure of the United States.

CERTIFICATE OF ATTENDING PHYSICIAN OR NURSE

FATHER FULL MOTHER

Wet ducts and solution was used in place

State of _____

Hospital _____ Primary Registration District No. _____

Registration District No. _____

RECEIVED

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
255-130071-843
County of Lehigh
City of Muncie

RECEIVED
JUN 6 1924

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

122106

No. _____ St. Registration District No. 66 State File No. _____
Hospital Muncie Primary Registration District No. 214 Local Registrar's No. 37

FULL NAME OF CHILD Thie Born
(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twins or other? <u>—</u>	and	Number in order of birth <u>—</u>	Legitimate? <u>Yes</u>	Date of Birth <u>April - 22, 1924</u> (Month) (Day) (Year)
--------------------------	--------------------------	-----	-----------------------------------	------------------------	---

What bactericidal solution was used in eyes? —

Number of child of this mother, including present birth <u>First</u>		Number of child of this mother now living, including present birth <u>First</u>	
FULL NAME <u>Paul Edward Bernard</u>	FATHER	FULL MAIDEN NAME <u>Elise Bentley</u>	MOTHER
RESIDENCE <u>Raymont Id.</u>		RESIDENCE <u>Raymont Id.</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>29</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>29</u> (Years)
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Wash.</u>	
OCCUPATION <u>Mail Carrier</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 1384 N. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) John F. West M.D.

Give names added from a supplemental report.

_____, 192_____

(Physician or midwife)
Address Muncie, Ind.
Filed 66 1924 P. Adams
Registrar.

Registrar.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **45458**
Registered No. **4**

1. PLACE OF DEATH

County of **Lewy**
City of **Winchester**

Registration District No. **52**
Primary Registration District No. **2129**
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Phil Born

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

April 30 1924
(Month) (Day) (Year)

7. AGE

0 Yrs. **0** Mos. **0** ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Idaho**

10. NAME OF FATHER

Paul Bevard

11. BIRTHPLACE OF FATHER

(State or Country) **Colorado**

12. MAIDEN NAME OF MOTHER

Alice Hedley

13. BIRTHPLACE OF MOTHER

(State or Country) **Oregon**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Paul Bevard**

(Address) **Orangmont Ida**

15.

Filed

5/1 1924 J. E. Deane
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April - 30 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April - 30 1924 to April - 30 1924
that I last saw h..... alive on **April - 30 1924**
and that death occurred on the date stated above, at **11:30** M.

The CAUSE OF DEATH* was as follows:

Phil Born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **John F. Gist**

M. D.

7 1924 (Address) **Winchester Ida**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

1003 Cemetery, Orangmont **5/1 1924**

20. UNDERTAKER

ADDRESS

Paul Bevard **Orangmont Ida**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 8 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

983-217-042-495
PLACE OF BIRTH
County of Latah Falls RECEIVED JUN 4 1924
City of Latah Falls BUREAU OF VITAL STATISTICS
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH 122284
No. _____ St. Registration District No. 37 State File No. _____
Hospital C. General Primary Registration District No. 1085 Local Registrar's No. _____
FULL NAME OF CHILD Anna Marguerite Ihler
(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? 4 and { Number in order of birth 1 Legitimate? yes Date of birth May 17 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 9 Number of child of this mother now living, including present birth 8

FATHER
FULL NAME Emil Ihler
RESIDENCE Filer Idaho
COLOR white AGE AT LAST BIRTHDAY 43 (Years)
BIRTHPLACE Missouri
OCCUPATION farming

MOTHER
FULL MAIDEN NAME Jillie Diercks
RESIDENCE Filer Ida
COLOR white AGE AT LAST BIRTHDAY 40 (Years)
BIRTHPLACE Nebraska
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 9:35 P.M. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.
_____, 1924

(Signature)

H. A. Swigert, M.D.

(Physician or midwife)

Address _____

Filed June 1 1924

Registrar.

Filer, Ida
John C. Coughlin
Registrar.

1. Name of the person: **ANTHONY**
 2. Date of birth: **1910**
 3. Place of birth: **NEW YORK**
 4. Present address: **1000 1st Ave New York City**
 5. Date of entry: **1910**
 6. Date of departure: **1910**
 7. Name of the ship: **SS. [illegible]**
 8. Name of the agent: **[illegible]**
 9. Name of the master: **[illegible]**
 10. Name of the crew: **[illegible]**
 11. Name of the passengers: **[illegible]**
 12. Name of the cargo: **[illegible]**
 13. Name of the vessel: **[illegible]**
 14. Name of the company: **[illegible]**
 15. Name of the port: **[illegible]**
 16. Name of the country: **[illegible]**
 17. Name of the state: **[illegible]**
 18. Name of the city: **[illegible]**
 19. Name of the street: **[illegible]**
 20. Name of the house: **[illegible]**
 21. Name of the apartment: **[illegible]**
 22. Name of the room: **[illegible]**
 23. Name of the floor: **[illegible]**
 24. Name of the building: **[illegible]**
 25. Name of the block: **[illegible]**
 26. Name of the lot: **[illegible]**
 27. Name of the section: **[illegible]**
 28. Name of the district: **[illegible]**
 29. Name of the ward: **[illegible]**
 30. Name of the precinct: **[illegible]**
 31. Name of the county: **[illegible]**
 32. Name of the state: **[illegible]**
 33. Name of the country: **[illegible]**

34. Name of the vessel: **[illegible]**
 35. Name of the company: **[illegible]**
 36. Name of the port: **[illegible]**
 37. Name of the country: **[illegible]**
 38. Name of the state: **[illegible]**
 39. Name of the city: **[illegible]**
 40. Name of the street: **[illegible]**
 41. Name of the house: **[illegible]**
 42. Name of the apartment: **[illegible]**
 43. Name of the room: **[illegible]**
 44. Name of the floor: **[illegible]**
 45. Name of the building: **[illegible]**
 46. Name of the block: **[illegible]**
 47. Name of the lot: **[illegible]**
 48. Name of the section: **[illegible]**
 49. Name of the district: **[illegible]**
 50. Name of the ward: **[illegible]**
 51. Name of the precinct: **[illegible]**
 52. Name of the county: **[illegible]**
 53. Name of the state: **[illegible]**
 54. Name of the country: **[illegible]**
 55. Name of the vessel: **[illegible]**
 56. Name of the company: **[illegible]**
 57. Name of the port: **[illegible]**
 58. Name of the country: **[illegible]**
 59. Name of the state: **[illegible]**
 60. Name of the city: **[illegible]**
 61. Name of the street: **[illegible]**
 62. Name of the house: **[illegible]**
 63. Name of the apartment: **[illegible]**
 64. Name of the room: **[illegible]**
 65. Name of the floor: **[illegible]**
 66. Name of the building: **[illegible]**
 67. Name of the block: **[illegible]**
 68. Name of the lot: **[illegible]**
 69. Name of the section: **[illegible]**
 70. Name of the district: **[illegible]**
 71. Name of the ward: **[illegible]**
 72. Name of the precinct: **[illegible]**
 73. Name of the county: **[illegible]**
 74. Name of the state: **[illegible]**
 75. Name of the country: **[illegible]**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
45833

1. PLACE OF DEATH

County of *Lincoln*
City of *Lincoln Falls*Registration District No. *37*
Primary Registration District No. *1085*
(No. County General Hosp. _____ St.)File No. _____
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Iker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant.
(Write the word.)

6. DATE OF BIRTH

May 16, 1924
(Month) (Day) (Year)

7. AGE

Still Born
IF LESS than 1 day
How many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

E. V. Iker

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Missouri
Mary M. Iker

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Filed *June 1* 19*24*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 16, 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 16, 1924, to May 16, 1924

that I last saw him alive on _____

and that death occurred on the date stated above, at *10 P.M.*

The CAUSE OF DEATH* was as follows:

Still Birth

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Prolonged Labor

(Duration) yrs. mos. 3 Hours

(Signed)

*H. A. Dwight, M.D.**May 17, 24* (Address) *Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. *None* In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

May 17, 1924

20. UNDERTAKER

ADDRESS

J. E. Probst
Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

195-267-042-864
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

122314

County of Twin Falls
City of Twin Falls
No. 519 Registration District No. 37 File No. _____
Hospital 752 2nd Ave Primary Registration District No. 1085 Registered No. _____
Twin Falls
FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of ♂ Child Male and 2 Number in order of birth 2 Legitimate? Yes Date of birth 5-7 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Ceryl 25-70

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME	<u>Charles Thomas Auerworth</u>	FULL MAIDEN NAME	<u>Ida Mae Young</u>
RESIDENCE	<u>Hansen</u>	RESIDENCE	<u>Hansen</u>
COLOR	<u>W</u>	COLOR	<u>W</u>
AGE AT LAST BIRTHDAY	<u>34</u> (Years)	AGE AT LAST BIRTHDAY	<u>27</u> (Years)
BIRTHPLACE	<u>Mo</u>	BIRTHPLACE	<u>Calo</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____ at _____ on the date above stated. (Born alive or stillborn) 11-30 A.M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

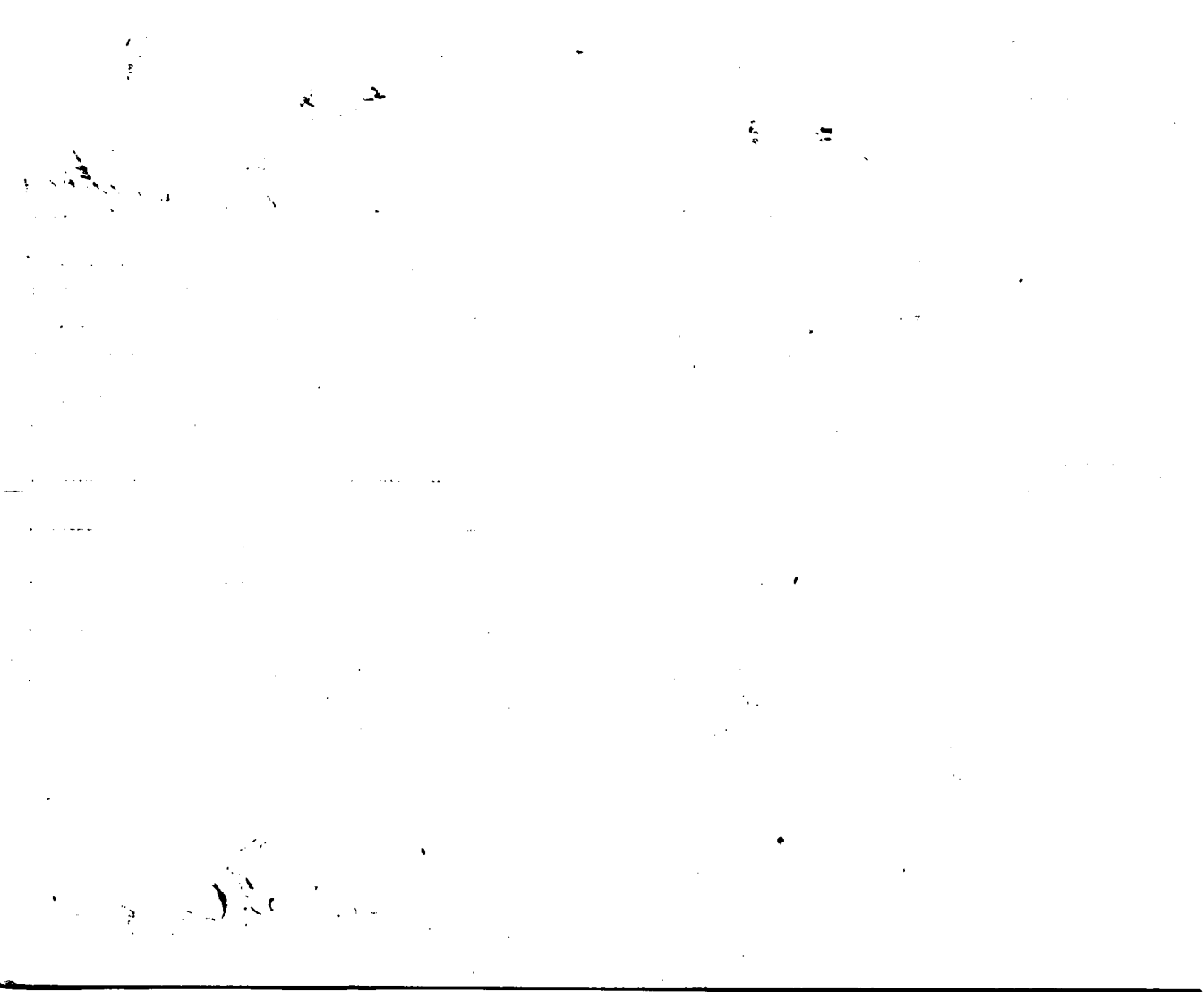
(Signature) Th. Mason

(Physician or midwife)

Give names added from a supplemental report.

Address Twin Falls, Ida.

Filed June 1 1924 John F. Coughlin
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A BUREAU FORM. Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19,

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37

City of Idaho Falls Primary Registration District No. 1085

(No. 752 2 Av East St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Ginsworth

State File No. 45829

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White

Single

(Write the word)

6. DATE OF BIRTH

May 7 1924
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
hrs. or min.?

0 Yrs. 0 Mos. 0 ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF Father

C. J. Ginsworth

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Young

13. BIRTHPLACE OF MOTHER

(State or Country)

Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. J. Ginsworth
Hansen

(Address)

15.

Filed June 1

1924

John H. Hansen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 7 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

T. S. Hansen

1924 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Twin Falls

DATE OF BURIAL

May 8 1924

20. UNDERTAKER

J. E. DeWitt

ADDRESS

Twin Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

617226-0 or -433
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

RECEIVED JUL 1 1924 CERTIFICATE OF BIRTH 122391

County of Ada

City of Prine

No. _____ St. _____

Registration District No. 2

File No. _____

Hospital St. Lukes

Primary Registration District No. 100

Registered No. 203

FULL NAME OF CHILD

Roberta Jane Way

(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin Triplet or other? <u>-</u> and { Number in order of birth <u>-</u>	Legitimate? <u>yes</u>	Date of birth <u>May 26</u> 192 <u>4</u> (Month) (Day) (Year)
----------------------------	---	------------------------	--

What bacterioidal solution was used in eyes? none

Number of child of this mother, including present birth 2nd Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Chas. W. Way
RESIDENCE 419 So 11th
COLOR white AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE So
OCCUPATION Auto Mechanic

MOTHER
FULL MAIDEN NAME Miss McCombe
RESIDENCE 419 So 11th St
COLOR white AGE AT LAST BIRTHDAY 29 (Years)
BIRTHPLACE Kansas
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 8:37 P M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) L. M. Taylor
M.D.
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address Boise, Idaho
Filed June 1 1924 R. H. Pratt
Registrar.

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

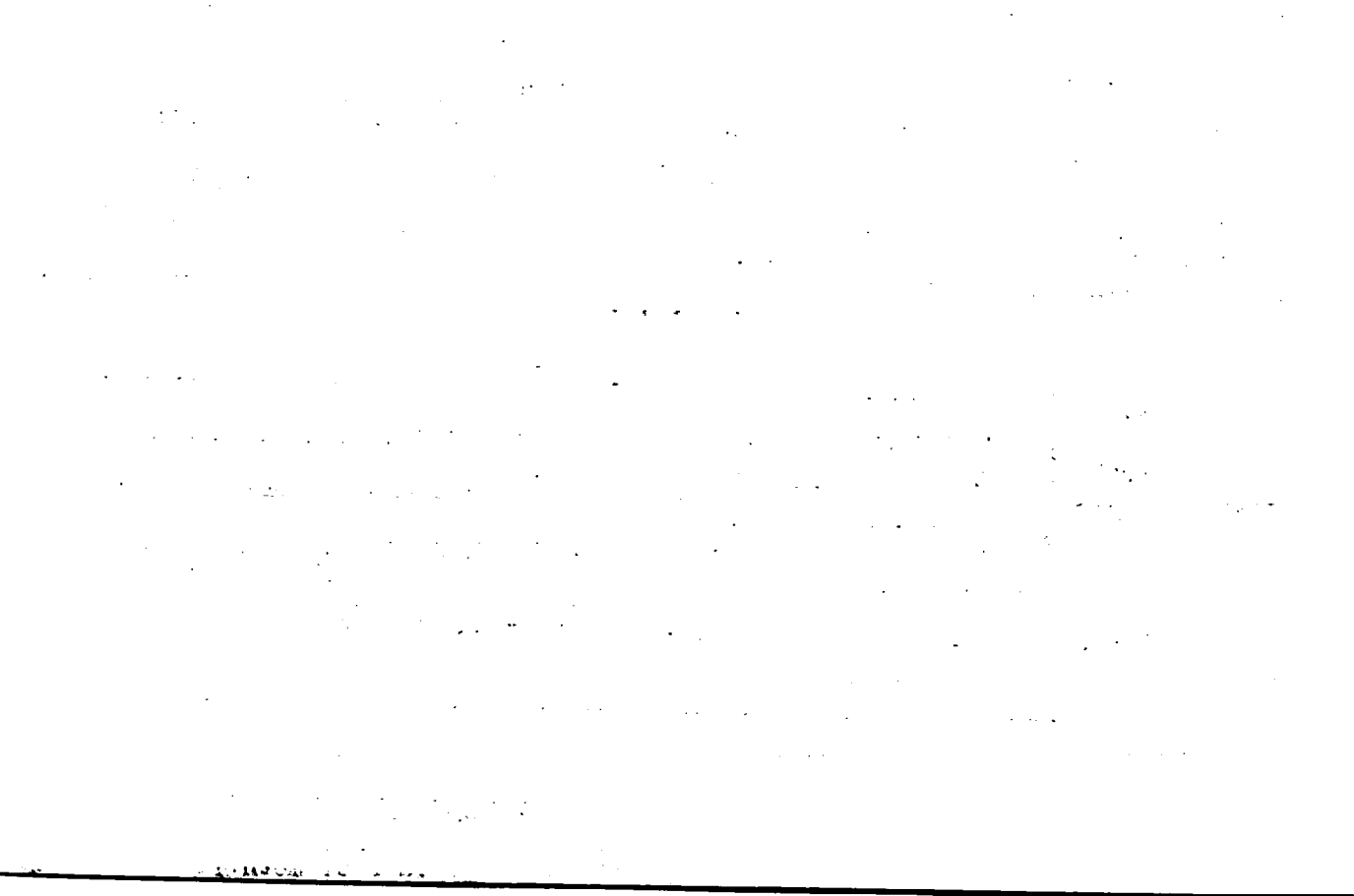
* * * * *

Place of Birth	(CITY	<u>Boise</u>	FILE NO.	<u>122391</u>
	(ST.	<u>Idaho</u>	DATE OF BIRTH	<u>May 26, 1921</u>
	(COUNTY	<u></u>	SEX OF CHILD	<u>Female</u>
FATHER		<u>Chas. W. Way</u>	MOTHER	<u>June McCombe</u> (MAIDEN NAME)

I HEREBY CERTIFY that the child herein described has been named:

Roberta ~~Wae~~ Jane

June McCombe Way
Signature of Father or Mother.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Way

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 6004

(No. St. Lukes Hospital St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 45539

Local Registrar's No. 144

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word)

6. DATE OF BIRTH

May 26

1924

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1
day how many
hrs. or
min.?

— Yrs. — Mos. — ds. —

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Father

Charles Way

11. BIRTHPLACE OF FATHER

(State or Country)

S. Dakota

12. MAIDEN NAME OF MOTHER

Jane M. Loube

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Krebs

(Address)

Boise Idaho

15.

Filled

May 27

19

24 Rex Park

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 26

1924

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 26

1924

to May 26

1924

that I last saw her alive on still born, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

apparently a premature abortion of placenta No. 1
fetal membranes left for several days (Duration) 8 1/2 yrs. months ds.

Contributory (Secondary) The mother says she has
caused gonorrhea, 10 days before the still birth (Duration) 10 yrs. months ds.

(Signed) J. M. Lay M. D.

5/27/1924 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

May 28 19 24

20. UNDERTAKER

Summer Krebs

ADDRESS

Boise Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

012-204-593
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

S

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

122604

County of Benewah
City of St. Marys
No. 32 St. Registration District No. 32 State File No. 122604
Hospital St. Marys Primary Registration District No. 2049 Local Registrar's No. 55
FULL NAME OF CHILD Infant Sahlman

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? None and Number in order of birth 1 Legitimate? Yes Date of birth June 4 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? NoneNumber of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Fred A. Sahlman
RESIDENCE St. Marys, Ida
COLOR White AGE AT LAST BIRTHDAY 33 (Years)
BIRTHPLACE Sweden
OCCUPATION Lumber Handler

MOTHER
FULL MAIDEN NAME Edith Vicklund
RESIDENCE St. Marys, Ida
COLOR White AGE AT LAST BIRTHDAY 33 (Years)
BIRTHPLACE Sweden
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn { Stillborn } at St. Marys Ida on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature)

Dr. Tobias
Physician or Midwife
(Physician or Midwife)

Address

Filed

St. Marys, Ida
July 7 1924
Dr. Tobias
Registrar.

Registrar.

Registrar.

44-38861-1000

Continuation of the report of the

1 copy of Book now available for reference only

... grand nombre de personnes, notamment les uns et les autres.

11/11/77

TRAC TA 200
YADIR

第 102 页

三、大學生之教育

067491280

is [redacted] saw only [redacted] who [redacted]

TO THE HONORABLE MEMBERS OF THE HOUSE OF REPRESENTATIVES
IN SENATE CHAMBERS, WASHINGTON, D. C.
JANUARY 10, 1917.
SIR:
I have the honor to acknowledge the receipt of your letter of the 7th inst.
and in reply to inform you that the same has been forwarded to the
proper authorities for their consideration.
Very respectfully,
J. H. HARRIS,
Director.

11-11-1964

३५१७९९

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of *Bennett*
City of *St. Maries*Registration District No. *32*
Primary Registration District No. *2049*
(No. *St. Maries Hosp. St.*)State File No. *45973*
Local Registrar's No. *37*If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

*Eve June Fahlman*If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

*white*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*single*
(Write the word)

6. DATE OF BIRTH

June 4 1924
(Month) (Day) (Year)

7. AGE

0 Yrs. *0* Mos. *0* ds.IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

St. Maries Ida.

10. NAME OF

Father

Fred Fahlman

11. BIRTHPLACE

OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME

OF MOTHER

Edith Vicklund

13. BIRTHPLACE

OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lind. Fahlman

(Address)

St. Maries Ida.

15.

Filed *June 9 1924* *Ballou*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 4 1924
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
June 4 1924 to *June 4 1924*that I last saw *her* alive on *June 4 1924*,
and that death occurred on the date stated above, at *?* M.

The CAUSE OF DEATH* was as follows:

Stillborn(Duration) *7* yrs. *0* mos. *0* ds.

Contributory

Secondary

acute toxemia of pregnancy in mother(Duration) *3* yrs. *0* mos. *0* ds.

(Signed)

*C. J. Robins M. D.**6/9/24* (Address) *St. Maries, Ida.**State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place In the
of death *0* yrs. *0* mos. *0* days. State *0* yrs. *0* mos. *0* ds.
Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

6-7 1924

20. UNDERTAKER

Mitchell & Mueggel

ADDRESS

St. Maries Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is
very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

353-215-009-465-
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonner

City of Sandpoint

No. _____ St. _____

Registration District No. 76

State File No. _____

Hospital _____

Primary Registration District No. 2155 Local Registrar's No. _____

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>June 15</u> , <u>1924</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	-----------------------------	---

What bactericidal solution was used in eyes? Silver Nitrate 1%

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME <u>Reid Finch Letson</u>	FULL MAIDEN NAME <u>LeVanche Emma Montgomery</u>	FULL NAME <u>Reid Finch Letson</u>	FULL MAIDEN NAME <u>LeVanche Emma Montgomery</u>
RESIDENCE <u>Sandpoint</u>	RESIDENCE <u>Sandpoint</u>	RESIDENCE <u>Sandpoint</u>	RESIDENCE <u>Sandpoint</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>21</u> (Years)
BIRTHPLACE <u>North Dakota</u>	BIRTHPLACE <u>Iowa</u>	BIRTHPLACE <u>Iowa</u>	BIRTHPLACE <u>Iowa</u>
OCCUPATION <u>Laborer</u>	OCCUPATION <u>Housewife</u>	OCCUPATION <u>Laborer</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 6:35 P. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) M. P. Wallentin

M. D.
(Physician or midwife)

Give names added from a supplemental report.

Address Sandpoint, Idaho

Filed July 3 1924 Viola Allen
Deputy Registrar.

Registrar.

122000

CERTIFICATE OF BIRTH

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICSPrimary Registration District No. 122000
Local Registrar's No. 122000
Registration District No. 122000
Date of Birth 12/20/1917

(Certificate of no value without full name of child)

Sex	Male	Age at Birth	0	Month	0	Day	0
Color	White	Weight	7	Pounds	0	Ounces	0
Length	20	Height	20	Inches	0	Centimeters	0

Silver Hittate

Number of child of this mother now living, including present birth 1

FATHER	MOTHER
NAME	NAME
RESIDENCE	RESIDENCE

FATHER	MOTHER
NAME	NAME
RESIDENCE	RESIDENCE
AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY
COLOR	COLOR
BIRTHPLACE	BIRTHPLACE
OCCUPATION	OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born on 12/20/1917 at 12:00 P. M.

(Signature) _____

(Physician or midwife)

When there was no attending physician or midwife, the father or mother should make this report. A witness must be one who believes the father's report.

This report should be on a supplemental report.

122

FORM V. S.-No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bonner
City of Sandpoint

If death occurred away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
CERTIFICATE OF DEATHRegistration District No. 78
Primary Registration District No. 2155
(No. _____ St.)STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. 46663
Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH

June 15, 1924
(Month) (Day) (Year)

7. AGE

Stillborn IF LESS than 1 day how many
_____ hrs. or
_____ Yrs. _____ Mos. _____ ds. _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Infant9. BIRTHPLACE
(State or Country)Idaho

10. NAME OF Father

R. F. Letson11. BIRTHPLACE OF FATHER
(State or Country)N. Dak.

12. MAIDEN NAME OF MOTHER

LaVarche Montgomery13. BIRTHPLACE OF MOTHER
(State or Country)Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. F. Letson
(Address) Sandpoint, Idaho

15.

Filed June 16, 1924 Viola Allen
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 15, 1924
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
_____ 19____ to _____ 19____,

that I last saw him alive on _____ 19____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stillbirth - polyhydramnion - 7 mo. gestation

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. W. Walker M. D.19____ (Address) Sandpoint, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.Where was disease contracted
if not at place of death? _____Former or
usual residence _____19. PLACE OF BURIAL OR REMOVAL Liberty Cemetery DATE OF BURIAL June 16, 192420. UNDERTAKER Edith Moon ADDRESS Sandpoint, Idaho

A stillbirth must be registered both as a birth and a death. The date of death ~~should~~ be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. "Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere ~~symptoms or terminal conditions~~, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

69-131-010-238
PLACE OF BIRTH

County of Bonneville
City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED
JUL 3 1924
CERTIFICATE OF BIRTH

122700 S

No. _____ St. _____ Registration District No. 73 State File No. _____
Hospital Spencer Primary Registration District No. 2140 Local Registrar's No. 203

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? 1 and { Number in order of birth 1 Legitimate? yes Date of birth May 31 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	<u>Wilbur Franklin Officer</u>	FULL MAIDEN NAME	<u>Anna Luella Schulz</u>
RESIDENCE	<u>Hunters Hot Springs Mont.</u>	RESIDENCE	<u>Hunters Hot Springs Mont.</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>37</u> (Years)	AGE AT LAST BIRTHDAY	<u>35</u> (Years)
BIRTHPLACE	<u>Livingston Mont.</u>	BIRTHPLACE	<u>Johnson Nebraska</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE:

I hereby certify that I attended the birth of this child, who was (Stillborn) at 4 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1924

(Signature) Harry L. Willson
M.D.
(Physician ~~or midwife~~)

Address Idaho Falls Idaho

Filed July 3 1924 William
Registrar. Registrar.

SHOWING THAT A CHILD, WHOSE BIRTHDAY IS WITHIN SIX MONTHS OF THE DATE OF THE BIRTH OF THE CHILD, IS BORN AND DIED IN THE SAME PLACE AND AT THE SAME TIME AS THE CHILD IN QUESTION.

CERTIFICATE OF BIRTH

1521002

No. _____ County of _____ City of _____
 Hospital _____ Full Name of Child _____
 Birth Date _____ Birth Time _____
 Sex _____ Color _____
 Place of Birth _____
 Occupation _____
 Signature of Physician _____
 Date _____

(Certificate of no name without full name of child)
 Full Name of Child _____
 Birth Date _____ Birth Time _____
 Sex _____ Color _____
 Place of Birth _____
 Occupation _____
 Signature of Physician _____
 Date _____

What accidental solution was used in case?
 Number of child of this mother, including present birth _____
 Number of child of this mother now living, including present birth _____

FATHER	MOTHER
NAME	NAME
RESIDENCE	RESIDENCE
COLOR	COLOR
AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY
BIRTHPLACE	BIRTHPLACE
OCCUPATION	OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who was _____ at _____ on the date above stated.

(Signature) _____
 (Physician or Midwife)
 Address _____
 Date _____

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bannock
City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. 73
Primary Registration District No. 2100
(No. JUN 7 1924 St.)

BUREAU OF VITAL STATISTICS

STAFF OFFICER

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 45584
Local Registrar's No. 71

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant
(Write the word)

6. DATE OF BIRTH

May 31 1924
(Month) (Day) (Year)

7. AGE

Still Born
0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho Falls, Ida

10. NAME OF FATHER

H. F. Officer

11. BIRTHPLACE OF FATHER

(State or Country) Mont.

12. MAIDEN NAME OF MOTHER

Anna Shultz

13. BIRTHPLACE OF MOTHER

(State or Country) Neb

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. F. Officer
(Address) Idaho Falls, Ida

15.

Filed May 31 1924 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 31 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31 1924 to May 31 1924

that I last saw him alive on May 31 1924, and that death occurred on the date stated above, at 3:00 M.

The CAUSE OF DEATH* was as follows:

Still born - mother had
Chloroform
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Signed) Dr. W. L. Wilkerson M. D.
May 31 1924 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?

Former or usual residence Idaho Falls, Ida

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls, Ida

DATE OF BURIAL

5/31 1924

20. UNDERTAKER

Edgewood

ADDRESS

Idaho Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

795-203-012-445
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
S
122702
County of Bonneville
City of Idaho Falls
No. _____ St. _____ Registered District No. 73 State File No. _____
Hospital Spencer Primary Registration District No. 124 Local Registrar's No. 201
FULL NAME OF CHILD Anna Marie Spencer
(Certificate of no value without full name of child)

Sex of Child Female Twin 1 and { Number in order of birth 5 Legitimate? yes Date of birth June 3 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth <u>5</u>		Number of child of this mother now living, including present birth <u>4</u>	
FULL NAME <u>George Moses Prestwich</u>	FATHER	FULL MAIDEN NAME <u>Ruth Murphee</u>	MOTHER
RESIDENCE <u>Lincoln Idaho</u>		RESIDENCE <u>Lincoln Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>45</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)
BIRTHPLACE <u>Marion Utah</u>		BIRTHPLACE <u>Ogden Utah</u>	
OCCUPATION <u>Rancher</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 1 30 a. m.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 1924

(Signature) Emilia

(Physician or midwife)

Address Idaho Falls

Filed 6/23 1924 Certified
Registrar.

10-11-1964

Medical Record No. 100-1

(Certificate of no value without this name of child)

1978

சென்னை

To be destroyed only in event of actual breach

Went back to the same place and found the same thing.

Number of child in this mother, including present birth

RECEIVED

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 08-11-2010 BY 60322
UCBAW/BJA

RECEIVED

Notes

BIRTHPLACE

NOIT44350

RENTAL

444

REFERENCE

0209

AGE AT LAST
BIRTHDAY

33A J9H7R1B

NOT A QUOTE

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

100-100000

I strongly recall that I attended the birth of this child, who was

1. John Doe

When there was no attending physician available then the father, householder, etc. should make his return. A child born could be one that neither brother nor sister other children of the same birth.

Wages (estimated) & other benefits

(9) 有価証券(株)

(FBI FILE NO. 100-37861)

NOTES

● 2010 年 10 月 1 日起

SOL

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each in order of birth stated.

294-186-614-294
PLACE OF BIRTH

RECEIVED
JUN 17 1924

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Blaine
City of Caldwell

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 3 State File No. 122747

Hospital _____ Primary Registration District No. 2005 Local Registrar's No. 78

FULL NAME OF CHILD Armas Norman Sims

(Certificate of no value without full name of child)

Sex of Child <u>M.</u>	Twin Triplet or other? <u> }</u>	and { Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>June 6</u> 192 <u>4</u> (Month) (Day) (Year)
------------------------	----------------------------------	---	------------------------	--

What bactericidal solution was used in eyes? no

Number of child of this mother, including present birth <u>1</u>		Number of child of this mother now living, including present birth <u>1</u>	
FATHER FULL NAME <u>Ray W Sims</u>		MOTHER FULL MAIDEN NAME <u>Alta Simon</u>	
RESIDENCE <u>Caldwell</u>		RESIDENCE <u>Caldwell</u>	
COLOR <u>cl</u>	AGE AT LAST BIRTHDAY <u>22</u> (Years)	COLOR <u>cl</u>	AGE AT LAST BIRTHDAY <u>22</u> (Years)
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Merchant</u>		OCCUPATION <u>Merchant</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 1924

Registrar.

(Signature) Ed Hill
(Physician or midwife)
Address Sta. 1, Idaho
Filed 6-7-1924 John S. Meyer
Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Canyon*
City of *Caldwell*

Registration District No. *3*

Primary Registration District No. *2003*

File No. *46654*

Registered No. *47*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Armenian Norman Sims

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

June 6 1924
(Month) (Day) (Year)

7. AGE

0 0 0
Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Canyon Co. Ida.

10. NAME OF FATHER

Ray W Sims

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Ellie Simons

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ray W Sims
Caldwell Ida
(Address)

15.

Filed

6-7-1924 *John B. Meyer*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 6 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

7:00 to *2:00* 19
that I last saw him alive on 19
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH was as follows:
Stillborn

Contributory
(Secondary)

(Signed)

19

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Star Ceme.

DATE OF BURIAL

6-8-1924

20. UNDERTAKER

C. V. Peckham

ADDRESS

Caldwell Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Spile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
391-104 @ 16-355
County of Cassia
City of Churchill
No. _____ St. _____
Hospital _____
Registration District No. 122 File No. XX / X
Primary Registration District No. 2/199 Registered No. 56
FULL NAME OF CHILD Crauer, Richard Key
(Certificate of no value without full name of child.)

Sex of Child Male Twin Triplet or other? ☒ and (Number in order of birth 1) Legitimate? Yes Date of birth 4-4-1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth _____ Number of child of this mother now living, including present birth _____

FATHER		MOTHER	
FULL NAME	<u>Arleth L. Crauer</u>	FULL MAIDEN NAME	<u>Gladys Lee</u>
RESIDENCE	<u>Churchill</u>	RESIDENCE	<u>Idaho</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>26</u> (Years)	AGE AT LAST BIRTHDAY	<u>27</u> (Years)
BIRTHPLACE	<u>Idaho</u>	BIRTHPLACE	<u>Utah</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____ at _____ M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

A. P. P. P. P.
M.D.
(Physician or midwife)

Give names added from a supplemental report.

Address

Filed

Burley Idaho
June 3 1924
A. P. P. P. P.
Registrar.

Registrar.

2

STATE OF
DEPARTMENT OF

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY Churchill FILE NO. 128610
(ST. _____ DATE OF BIRTH May 29
(COUNTY Cassia SEX OF CHILD male

FATHER Asleth Crane MOTHER Gladys Lee
(MAIDEN NAME)

I HEREBY CERTIFY that the child herein described has been named:

Richard Rex Craner

Mrs. Adith. Lane
Signature of Father or Mother.

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

Office, Idaho

Dear Madam:

The name of your baby was not listed in on the birth certificate sent to this office. It is of vital importance to have the name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS

_____	FILE NO.	_____	CITY) Please to Birth
_____	DATE OF BIRTH	_____	STATE	
_____		_____	COUNTY	

NOTICE

(NAME NAME)

I HEREBY CERTIFY that the child herein described has been named:

Signature of Parent or Guardian

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

CERTIFICATE OF DEATH 46075

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Cassia
City of Churchill

Registration District No. 120
Primary Registration District No. 297
(No. St.)

State File No. XV 114
Local Registrar's No. 47

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Cramer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Male White Infant
(Write the word)

6. DATE OF BIRTH

Apr. 4 1924
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF Father

Arthur L. Cramer

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Gladys Lee

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. P. Oldham

15.

Filed

June 30 - 1924
R. H. McLean
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr. 4 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 4 1924 to Apr. 4 1924, that I last saw him alive on 1924, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows: .

Intrauterine accident
Death about 24 hrs.
Anthrax mos. ds.

Contributory (Secondary)

nothing specific yrs. mos. ds.

(Signed)

4. 1924

(Address)

Barley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. days, State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

122831

CERTIFICATE OF BIRTH

County of CassiaCity of BeeloNo. 813203016994 St.Registration District No. 117

File No. _____

Hospital _____

Primary Registration District No. 2196Registered No. 2864

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child.)

Sex of Child FTwin
Triplet
or other?

{ and }

Number
in order
of birthLegiti-
mate?YesDate of
birth6-31924

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes? Silver NitrateNumber of child of this mother, including present birth... 13Number of child of this mother now living, including present birth... 11FULL
NAME

FATHER

J. O. YatesFULL
MAIDEN
NAME

MOTHER

Alice Zimmerman

RESIDENCE

Beelo, Ida

RESIDENCE

Beelo, Ida

COLOR

whiteAGE AT LAST
BIRTHDAY52

(Years)

COLOR

whiteAGE AT LAST
BIRTHDAY41

(Years)

BIRTHPLACE

Utah

BIRTHPLACE

Ohio

OCCUPATION

Farming

OCCUPATION

Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn, at Beelo, Ida, on the date above stated.

M.

(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Dr. J. C. Patterson

(Physician or midwife)

Give names added from a supplemental report.

Address

Burley, Ida

Filed

6-71924Dr. J. C. Patterson

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.Each
Certificate

2

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Cassia
 City of Butte

Registration District No. 117
 Primary Registration District No. 2196
 (No. 117 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 46089
 Registered No. 722

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

June 3 1924
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. ds. IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Stillborn

9. BIRTHPLACE

(State or Country)

Declo, Ida.

10. NAME OF FATHER

J. O. Yates

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Alice Timmerman

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. O. Yates
Declo, Ida.

15.

Filed 7-7 1924 H. J. C. Patterson
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 3 1924
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 3 1924 to June 3 1924

that I last saw him alive on June 3 1924

and that death occurred on the date stated above, at Declo, Ida.

The CAUSE OF DEATH* was as follows:

Stillborn - Premature detachment of Placenta.

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

H. J. C. Patterson M. D.
6-4 1924 (Address) Butte, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Declo, Ida.

DATE OF BURIAL

6-4 1924

20. UNDERTAKER

None

ADDRESS

None

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

155-215021-466

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Franklin

City of Spokane Station

JUN 13 1924 CERTIFICATE OF BIRTH

122902

No. 27 St. 27

BUREAU OF VITAL
STATISTICS

File No.

Hospital

Primary Registration District No. 2119

Registered No. 143

FULL NAME OF CHILD

Subel Jenkins

Certificate of no value without full name of child.)

Sex of Child Female

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

yes

Date of birth May 15 1924
(Month) (Day) (Year)

(To be answered only in event of plural births)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 6

Number of child of this mother now living, including present birth 4

FULL
NAME

W.B. Jenkins

FATHER

FULL
MAIDEN
NAME

Hazel Lavema Moore

MOTHER

RESIDENCE

Preston

RESIDENCE

Preston

COLOR

W

AGE AT LAST
BIRTHDAY 29
(Years)

COLOR

W

AGE AT LAST
BIRTHDAY 27
(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Idaho

OCCUPATION

Entirely man

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 11 P.M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

E.S. Milford
Physician
(Physician or midwife)

Give names added from a supplemental report.

 , 1924

Address

Preston Idaho

Filed

1924

Registrar.

Registrar.

2

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should
state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is
very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of FranklinRegistration District No. 27City of Oneida StationPrimary Registration District No. 2119(No. St.)If death occurs away from
usual residence, give facts
called for under special in-
formation.2. FULL NAME Sybil JenksState File No. 46162Local Registrar's No. 36If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single (Write the word)

6. DATE OF BIRTH

May 15, 1924.

(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.IF LESS than 1
day how many
0 hrs. or
0 min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work None(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) Oneida Station, Idaho.

10. NAME OF

Father Wilford Jenks,

11. BIRTHPLACE

OF FATHER
(State or Country) Weston, Idaho.

12. MAIDEN NAME

OF MOTHER Hasel Moore,

13. BIRTHPLACE

OF MOTHER
(State or Country) Rosevelt, Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. C. C. Culbert(Address) Oneida Station, Idaho.

15.

Filed June 3 1924Local Registrar C. C. Culbert

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 15, 1924.

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
5--15-- 1924 to 5--15-- 1924,that I last saw her alive on 1924,
and that death occurred on the date stated above, at 10:30 AM

The CAUSE OF DEATH* was as follows:

Stillborn(Duration) yrs. mos. ds.Contributory
(Secondary)(Duration) yrs. mos. ds.(Signed) E. S. Milford M. D.May 16, 1924 (Address) Preston, Idaho.*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Preston CemeteryMay 17, 1924.

20. UNDERTAKER

Brickson,Preston, Idaho.
P

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

INFADING INK—THIS IS A PERMANENT RECORD
child at birth, a SEPARATE RETURN must be made for each
number of each, in order of birth stated.

TWINS

122903

122903 A

(CREATED)

BORN ALIVE AND

STILLBORN

PLACE OF BIRTH

693 120 71-266

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

RECEIVED

JUN 13 1924

CERTIFICATE OF BIRTH

122903 4A

County of Franklin

City of Clifton

No. _____ St. _____

Registration District No. _____

File No. _____

Hospital _____

Primary Registration District No. 2119

Registered No. 109

FULL NAME OF CHILD

Melvin B. Williams

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin <u>Twins</u> } and { Number in order of birth Triplet or other? (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of birth <u>May 20</u> 192 <u>4</u> (Month) (Day) (Year)
--------------------------	---	------------------------	--

What bacteriocidal solution was used in eyes? Argrol

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 3

FATHER
FULL NAME James L. Williams
RESIDENCE Clifton

MOTHER
FULL MAIDEN NAME Hazel Bowman
RESIDENCE Clifton

COLOR W AGE AT LAST BIRTHDAY 32 (Years)

COLOR W AGE AT LAST BIRTHDAY 28 (Years)

BIRTHPLACE Clifton Ida
owner

BIRTHPLACE Fort Wain Id
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

that I attended the birth of this child, who was #1 Born alive #2 Stillborn 1230 am.
stated. (Born alive or stillborn)

was no attending physician or father, householder, etc., return. A stillborn child is breathes nor shows other evi-
birth.

(Signature) E. S. Milford
Physician
(Physician or midwife)

from a supplemental report.

Address Preston Idaho

Filed June 10 1924 A. R. Custer

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

RECEIVED

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Kootenai

JUL 9 1924

123125

City of Coeur d'Alene

BUREAU OF CERTIFICATE OF BIRTH

No. 599126 028 692St. Registration District No. 30State File No. 1831

Hospital

Primary Registration District No. 1057Local Registrar's No. 1831FULL NAME OF CHILD Elmer Floyd Erickson

(Certificate of no value without full name of child)

Sex of Child

MaleTwin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legitimate?

yes

Date of birth

May 261924

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 2Number of child of this mother now living, including present birth 1

FULL NAME

FATHER

Mark A. Erickson

RESIDENCE

Coeur d'Alene, Ida.

COLOR

White

AGE AT LAST

BIRTHDAY

28

(Years)

BIRTHPLACE

Wash

OCCUPATION

Carpenter

FULL MAIDEN NAME

MOTHER

Mary Gladys F. Fife

RESIDENCE

Coeur d'Alene, Ida.

COLOR

White

AGE AT LAST

BIRTHDAY

28

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive { Stillborn } at 11 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 1924

Registrar.

(Signature)

J. C. Meyer M.D.
Physician

(Physician or midwife)

Address

Coeur d'Alene, Ida.

Filed

7/7 1924D. D. Drennon

Registrar.

STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

County of _____
 City of _____
 Name of child _____
 Sex _____
 Date of birth _____
 Primary Registration District No. _____
 State File No. _____

(Certificate of no value without full name of child)

Date of birth (Month) (Day) (Year)	Legality (Marry) (Not)	(To be answered only in case of birth in hospital) Was in hospital? (Yes) (No) Was in other place? (Yes) (No) Was at birth? (Yes) (No)
---------------------------------------	---------------------------	---

Where hospitalization was used in event?

FATHER		MOTHER	
NAME	NAME	NAME	NAME
RESIDENCE	RESIDENCE	RESIDENCE	RESIDENCE
COLOR	COLOR	COLOR	COLOR
AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY
BIRTHPLACE	BIRTHPLACE	BIRTHPLACE	BIRTHPLACE

Number of child of this mother, including present birth _____
 Number of child of this father, including present birth _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____

(Signature) _____

(Address of child) _____

Address _____

1937

After medical advice from a supplemental report shows other evidence of life after birth, child is one that birth practices not etc. should make this certain. A birth record registers from the other perspective. When there was no attending physician as registered from the other perspective.

RECEIVED
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS
 IDAHO
 JAN 10 1937

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD
N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH
in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Kootenai
City of _____Registration District No. 30
Primary Registration District No. 1057
(No. Near P.O. A St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 45721
Registered No. 1389If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Baby EricksonIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

May 26 1924
(Month) (Day) (Year)

7. AGE

— Yrs. — Mos. — ds.

IF LESS than 1 day
how many — hrs.
or — min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERMark Erickson11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho12. MAIDEN NAME
OF MOTHERGladys White13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. P. Roper

(Address)

P.O. Box 224 Route #5

15.

Filed June 5 1924D. D. Dreman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 26 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2 1924, to 26 1924
that I last saw him alive on 26 1924and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Still born (Marginal
placental previa)
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

27 1924 (Address) Corvallis, Ida*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cemetery May 27 1924

20. UNDERTAKER

ADDRESS

P. B. Mooney Payson, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Latah RECEIVED
City of Arvon
No. 292-207029-238 State Registration District No. 2147 State File No. 123150

Hospital STANLEY Primary Registration District No. 67 Local Registrar's No. 19

FULL NAME OF CHILD Mary Lissou

(Certificate of no value without full name of child.)

Sex of Child <u>7</u>	Twin Triplet or other? <u>✓</u>	and { Number in order of birth <u>✓</u>	Legitimate? <u>yes</u>	Date of birth <u>4-7-1924</u>
(To be answered only in event of plural births)				(Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth <u>1</u>		Number of child of this mother now living, including present birth <u>0</u>	
FATHER	MOTHER	FATHER	MOTHER
FULL NAME <u>Harold K. Lissou</u>	FULL MAIDEN NAME <u>Edna Schwartz</u>	FULL NAME <u>Harold K. Lissou</u>	FULL MAIDEN NAME <u>Edna Schwartz</u>
RESIDENCE <u>Arvon</u>	RESIDENCE <u>Arvon</u>	RESIDENCE <u>Arvon</u>	RESIDENCE <u>Arvon</u>
COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>24</u> (Years)	COLOR <u>W.</u>	AGE AT LAST BIRTHDAY <u>21</u> (Years)
BIRTHPLACE <u>Ore</u>	BIRTHPLACE <u>Arvon</u>	BIRTHPLACE <u>Ore</u>	BIRTHPLACE <u>Arvon</u>
OCCUPATION <u>Clerk gen. store</u>	OCCUPATION <u>Arvon</u>	OCCUPATION <u>Clerk gen. store</u>	OCCUPATION <u>Arvon</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 9 10 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Dr. Farist
Physician
(Physician or midwife)

Give names added from a supplemental report.

Address

Filed

1924

Registrar.

Registrar.

THIS IS A COPY OF THE ORIGINAL RECORD OF BIRTH OF THE CHILD. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF BIRTHS AND DEATHS.

133120

2

STATE OF TEXAS
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

No. 133120

County of Tarrant

City of Fort Worth

Hospital

DATE NAME OF CHILD

(Certificate of no name without full name of child)

Sex of Child

Color

Birthplace

Age at last birthday

Color

Birthplace

Occupation

Full name of mother

Residence

Color

Birthplace

Age at last birthday

Color

Birthplace

Occupation

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was delivered at

Signature

Address

When there was no attending physician or midwife, then the father, mother, or grandparent should make this return. A birth record is not valid unless it is signed by one of these persons.

When there was no attending physician or midwife, then the father, mother, or grandparent should make this return. A birth record is not valid unless it is signed by one of these persons.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No.

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

7. AGE

IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
Father11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

2-3 1924 to 4-9 1924

that I last saw her alive on never 19

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Stillborn - from
menia

(Duration) 0 yrs. 0 mos. 4 ds.

Contributed by
(Secretary)

(Duration) 2 yrs. 0 mos. 0 ds.

(Signed) R. C. Faust M. D.

(Address) Deary

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place In the
of death yrs. mos. days. State yrs. mos. ds.Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cremated at home

4-9 1924

20. UNDERTAKER

ADDRESS

Local Registrar

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

County of

City of

No.

St.

Registration District No.

State File No.

Hospital

Primary Registration District No.

Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child

Twin
Triplet
or other?and (Number
in order
of birth)Legiti-
mate?Date of
birth

(Month)

(Day)

1924
(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FULL
NAME

FATHER

FULL
MAIDEN
NAME

MOTHER

RESIDENCE

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

COLOR

AGE AT LAST
BIRTHDAY

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ^{born alive} stillborn ^{at} ^{6:30 A.} M.
on the date above stated.

*When there was no attending physi-
cian or midwife, then the father, house-
holder, etc., should make this return.
A stillborn child is one that neither
breathes nor shows other evidence of
life after birth.

(Signature)

(Physician or midwife)

Give names added from a supplemental report.

Address

Filed

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

46159

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH *Idaho* Registration District No. *2147*
County of *Blaine* Primary Registration District No. *67*
City of *Blaine* St. *Blaine*
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME *Gordon Anderson*
State File No. *3*
Local Registrar's No. *13*
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M.* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*
(Write this word)

6. DATE OF BIRTH

4-23-924
(Month) (Day) (Year)

7. AGE

0 Yrs. *0* Mos. *0* ds.

IF LESS than 1 day show many hrs. or min.?
0

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)
fetus

9. BIRTHPLACE

(State or Country)

10. NAME OF

Father

Samuel E. Anderson

11. BIRTHPLACE

OF FATHER

(State or Country)

12. MAIDEN NAME

OF MOTHER

Goldie Clark

13. BIRTHPLACE

OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

R. G. Faust
Blaine

15.

Filed

*4-25*19 *24*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4-23-924
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

19 to *19*,
that I last saw him alive on *never* *19*,
and that death occurred on the date stated above, at *1* M.

The CAUSE OF DEATH* was as follows:

Slow + difficult delivery

(Duration) yrs. mos. ds.

Contributor

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

4/25/24

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pine Crest Cem *4-24-1924*

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

1782

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of MadisonCity of SugarNo. 993213033842

St.

RECEIVED

JUN 13 1924

CERTIFICATE OF BIRTH 123210

Hospital

BUREAU OF

Registration District No. 100

State File No.

Primary Registration District No. 2178

Local Registrar's No.

792

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

FemaleTwin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?YesDate of
birth4-13-1924

(Month) (Day) (Year)

What bactericidal solution was used in eyes? 2% mercuric chlorideNumber of child of this mother, including present birth 1Number of child of this mother now living, including present birth 0FULL
NAME

FATHER

Warren A. Ricks

RESIDENCE

Sugar

COLOR

WhiteAGE AT LAST
BIRTHDAY 28
(Years)

BIRTHPLACE

Idaho

OCCUPATION

FarmerFULL
MAIDEN
NAME

MOTHER

Gladys J. Huskison

RESIDENCE

Sugar

COLOR

WAGE AT LAST
BIRTHDAY 20
(Years)

BIRTHPLACE

Utah

OCCUPATION

HW

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE:

I hereby certify that I attended the birth of this child, who was Stillborn at 930 a N. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Lincoln F. Ricks

(Physician or midwife)

Address

Riceburg, Idaho

Filed

6/7

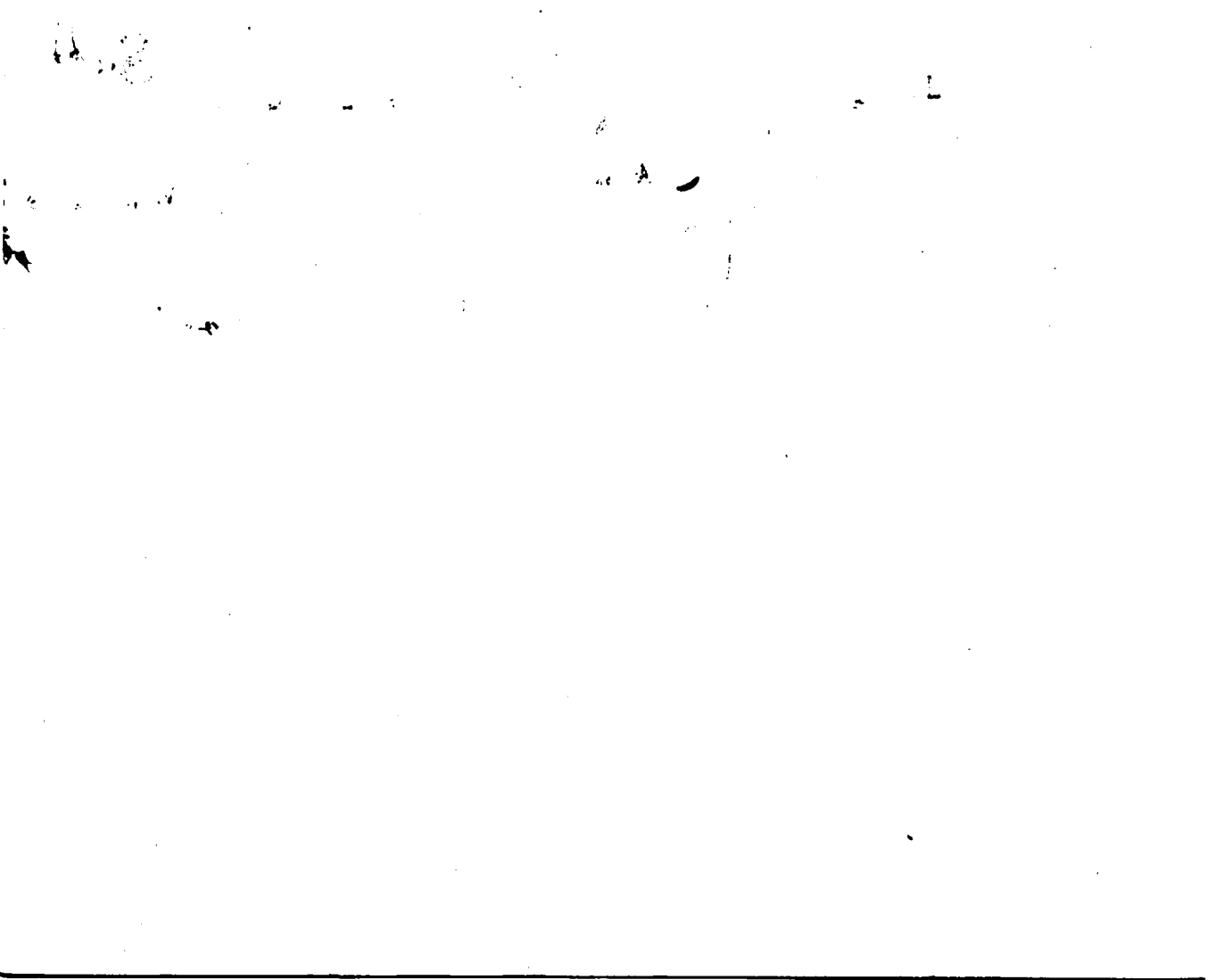
192

7

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED

MAY 14 1924

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Madison

City of Rogan

(No. _____)

(St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Rich

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 45466

Registered No. 138

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Girl

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Born
(Write the word.)

6. DATE OF BIRTH

April
(Month)

14
(Day)

1924
(Year)

7. AGE

____ yrs. ____ mos. ____ da.

IF LESS than 1 day
how many ____ hrs. or ____ mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Born

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Rogan Idaho

10. NAME OF FATHER

Warren Richs

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Gladys Huskinson

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. W. Huskinson

(Address)

Rogan

15.

Filed

4/14

19124

J. W. Huskinson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April
(Month)

14
(Day)

19124
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

4-14-1924 to 4-14-1924

that I last saw him alive on 4-14-1924

and that death occurred on the date stated above, at 3:30 A. M.

The CAUSE OF DEATH* was as follows:

Strangulation of cord at birth
(Stillborn)

(Duration) ____ yrs. ____ mos. ____ ds.
Contributory (Secondary) Constricted pelvis of mother

(Duration) ____ yrs. ____ mos. ____ ds.
4/ (Signed) Lois A. Rich M. D.
22 1924 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rogan

4/14 19124

20. UNDERTAKER

ADDRESS

From

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of MinnesotaCity of HeyburnNo. 219-109(034945)

St.

Registration District No. 19State File No. 123252

Hospital

Primary Registration District No. 2013Local Registrar's No. 66

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child)

Sex of
ChildmaleTwin
Triplet
or other?

}

and {

Number
in order
of birthLegiti-
mate?yesDate of
birthJune 9 1924

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

1

Number of child of this mother now living, including present birth

0FULL
NAME

FATHER

Adriaans Barendregt

RESIDENCE

Heyburn

COLOR

whiteAGE AT LAST
BIRTHDAY44
(Years)

BIRTHPLACE

Holland

OCCUPATION

FarmerFULL
MAIDEN
NAME

MOTHER

Trintje Rumia

RESIDENCE

Heyburn

COLOR

whiteAGE AT LAST
BIRTHDAY31
(Years)

BIRTHPLACE

Holland

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 5 A. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

Registrar.

(Signature)

E. D. Edmore

(Physician or midwife)

Address

Refert Idaho

Filed

June 9 1924

Registrar.

FORM V. S. No. 5-25 M. 1-18-13

1. PLACE OF DEATH

County of *Michigan*
City of *Bay City*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED
CERTIFICATE OF DEATH
Registration District No. *19*
Primary Registration District No. *20157*
BUREAU OF VITAL STATISTICSState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *46191*Registered No. *19*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH.

June 1
(Month) (Day)*1924*
(Year)

7. AGE

0 Yrs. *0* Mos. *0* ds.IF LESS than 1 day
how many *0* hrs. or
0 min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Bay City, Michigan

10. NAME OF FATHER

Adrius Parendrecht

11. BIRTHPLACE OF FATHER

(State or Country)

Holland

12. MAIDEN NAME OF MOTHER

Tsyutje Ruia

13. BIRTHPLACE OF MOTHER

(State or Country)

Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Adrius Parendrecht

(Address)

Bay City, Michigan

15.

Filed

*June 10 1924**E. D. Elmore*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 9
(Month) (Day)*1924*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Stullborn 191.....

that I last saw him alive on 191.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stullborn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *E. D. Elmore* M. D.*6-10-24* (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191.....

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of MinimookaCity of P.O. AcquiaCERTIFICATE OF BIRTH **123276**No. 689-112-034-489 St. Registration District No. 17 State File No. 70Hospital _____ Primary Registration District No. 2913 Local Registrar's No. 70FULL NAME OF CHILD (Clement) Whitworth

(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin Triplet or other? _____ } and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>June 12 1924</u> (Month) (Day) (Year)
--------------------------	---	------------------------	---

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4

FATHER
FULL NAME Jesse J Whitworth
RESIDENCE Acquia Idaho
COLOR white AGE AT LAST BIRTHDAY 41 (Years)
BIRTHPLACE Oregon
OCCUPATION farmer

MOTHER
FULL MAIDEN NAME Millie Whittle
RESIDENCE Acquia Idaho
COLOR white AGE AT LAST BIRTHDAY 37 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 2:30 P.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Leland Frazier

(Physician or midwife)

Address

Rupert, Idaho

Filed

1924

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

81

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1885

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1

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho JUL 11 1924

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

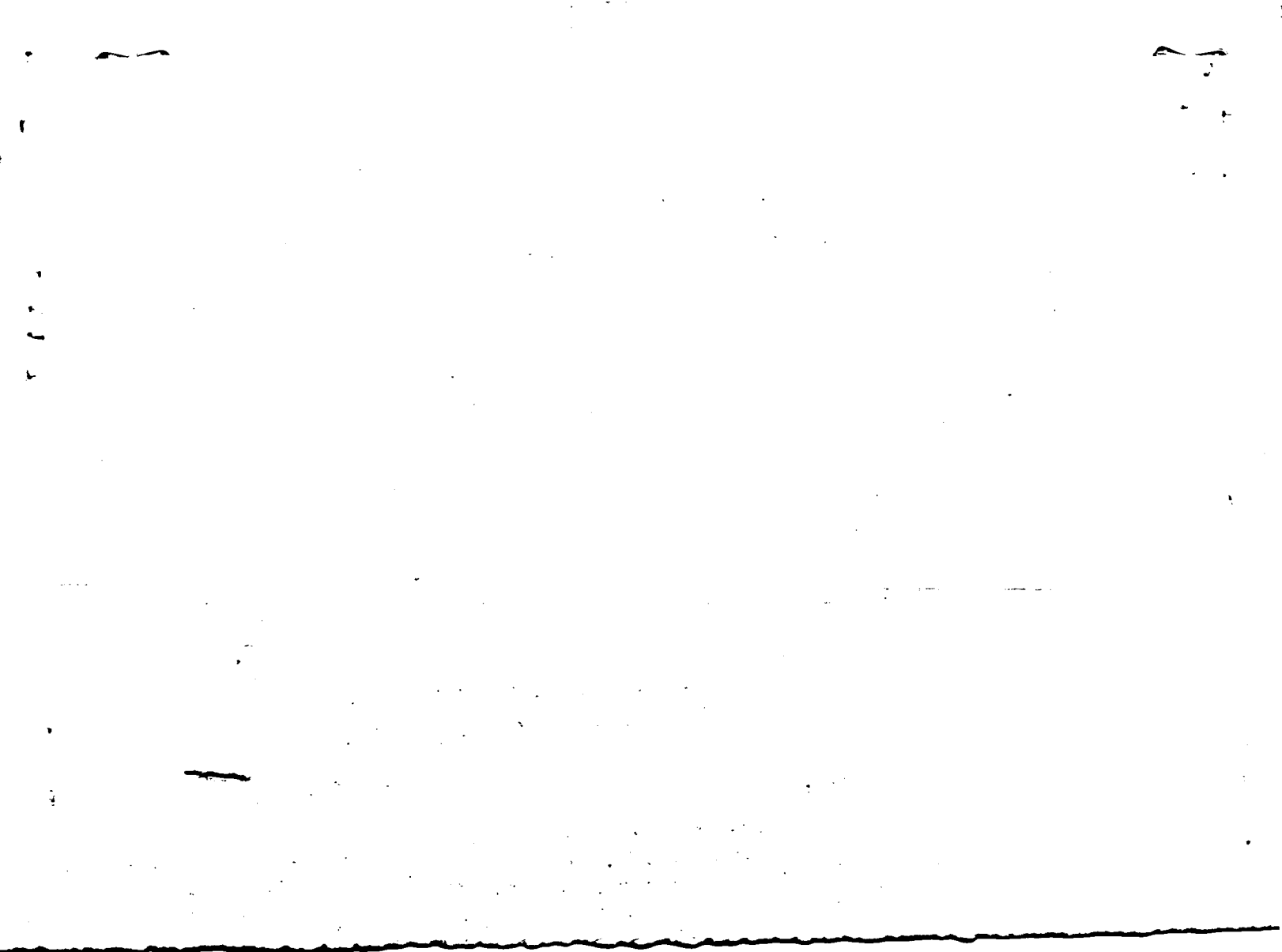
* * * * *

Place of Birth	(CITY <u>Boise</u>	FILE NO. <u>123276</u>
	(ST. <u>Idaho</u>	DATE OF BIRTH <u>12 June</u>
	(COUNTY <u>Blaine</u>	SEX OF CHILD <u>Male</u>
FATHER <u>James J. Whitworth</u>		MOTHER <u>Lena M. Whittle</u> (MAIDEN NAME)

I HEREBY CERTIFY that the child herein described has been named:

William John Whitworth

James J. Whitworth
Signature of Father or Mother.



July 23, 1924.

Mrs. Jesse J. Whitworth,

Acquia, Idaho.

Dear Madam:

Responsive to your letter of the 21st inst. we have to advise upon looking up the report of birth of your child we note the physician stated it was "stillborn" and it was an oversight that a request was sent to you for the name. When certificates are filed in this department without a name a request is sent out to the parents for the name in order to complete the certificate and it is not our intention to write for names where the physician reports it was stillborn. Sometimes parents give a stillborn child a name but usually they do not.

Respectfully yours.

F. W. Almond, M. D.
Director, Public Health Service.

July 23, 1934

Mrs. Jesse L. Whitworth,

Acquia, Idaho.

Dear Madam:

Responsive to your letter of the 21st inst. we have
to advise upon looking up the report of birth of your child
we note the physician stated it was "stillborn" and it was
an oversight that a request was sent to you for the name.
When certificates are filed in this department with a name
a request is sent out to the parents for the name in order to
complete the certificate and it is not an intention to write for
names where the physician reports it was stillborn. Sometimes
parents give a stillborn child a name but usually they do not.

Respectfully yours,

E. W. Alford, M. D.
Director, Public Health Service.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

443.112 035 819
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 123289

County of Nes Perce

City of Lewiston

No. _____ St. _____

Registration District No. 96

File No. _____

Hospital St. Josephs

Primary Registration District No. 1002

Registered No. _____

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	<u>Twins</u> Triplet or other?	and	Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>6-12-1924</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth... 1 Number of child of this mother now living, including present birth... none

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>John Martin Mulholland</u>	<u>Bozyl Idaho</u>	<u>Sela J. Harris</u>	<u>Bozyl Idaho</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)
BIRTHPLACE <u>Washington</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Engineer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____ at _____ on the date above stated. (Born alive or stillborn) 6:30 P.M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

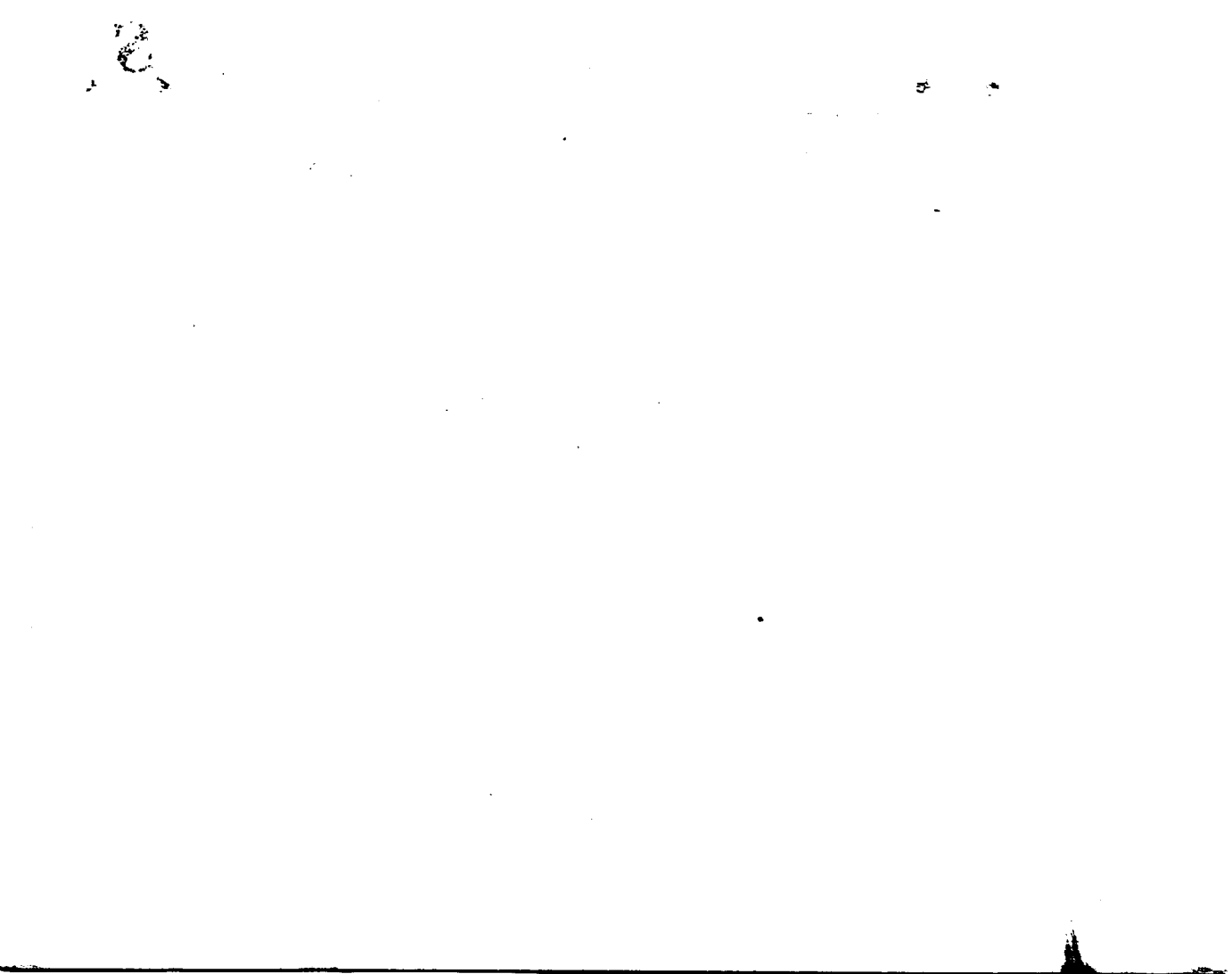
(Signature) A. C. Carrow

(Physician or midwife)

Give names added from a supplemental report.

Address Lewiston, Idaho

Filed July 11 1924 Ernest E. Bruce
Registrar.



CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Myer
City of LewistonRegistration District No. 96
Primary Registration District No. 1009
(No. 9 St.)File No. 46199
Registered No. 46199

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Margaret Letitia Mulrooney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemale White Single
(Write the word.)

6. DATE OF BIRTH

June 12 1924
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J. M. Mulrooney

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Lela J. Harris

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed July 8 1924Dwan E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 12 1924
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
June 12 1924 to June 12 1924
that I last saw her alive on June 12 1924and that death occurred on the date stated above, at 11 M.
The CAUSE OF DEATH* was as follows:Stillborn(Duration) Yrs. mos. ds.
Contributory Don't know
(Secondary)(Duration) Yrs. mos. ds.
(Signed) O. C. Pearson M. D.
19 24 (Address) Lewiston Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston Ida.
20. UNDERTAKER
Cassas and Co.

DATE OF BURIAL

8/13/24

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

863-201-035-635
PLACE OF BIRTHSTATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C—25m-9-8-15

S

CERTIFICATE OF BIRTH

County of Key RiverCity of Myrtle

No. _____ St. _____

Registration District No. 128File No. 123304

Hospital _____

Primary Registration District No. Caldesac

Registered No. _____

FULL NAME OF CHILD StillbornSex of Child FemaleTwin
Triplet
or other?and Number
in order
of birth

Legitimate?

Date of Birth 3 1 1924

(Month) (Day) (Year)

FULL NAME FATHER

FATHER

FULL MAIDEN NAME MOTHER

MOTHER

RESIDENCE Myrtle IdahoRESIDENCE Myrtle IdahoCOLOR WhiteAGE AT LAST BIRTHDAY 42

(Years)

COLOR WhiteAGE AT LAST BIRTHDAY 39

(Years)

BIRTHPLACE AustriaBIRTHPLACE WashingtonOCCUPATION FarmerOCCUPATION HousewifeNumber of child of this mother, including present birth 11Number of children of this mother now living, including present birth 9

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE *

I hereby certify that I attended the birth of this child, who was Stillborn, at 5:15 A. M. on the date above stated.

(Born alive or stillborn)

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) George Guignard

(Physician or midwife)

Given names added from a supplemental report.

Address Caldesac IdahoFiled March 24 1924

Registrar

Registrar

12

2

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Shopman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C—25m-9-8-15

CERTIFICATE OF BIRTH

S 123307

County of Keyser
City of Caldese IdsRegistration District No. 128

File No. _____

No 316-106-035-296 St.Primary Registration District No. Caldese

Registered No. _____

Hospital _____

FULL NAME OF CHILD Stillborn Laurence

Sex of Child

MaleTwin
Triplet
or other?{ and } Number
in order
of birthLegiti-
mate?yes

Date of Birth

3 6 24
(Month) (Day) (Year)

FULL NAME

Reias H. Laurence

FATHER

FULL MAIDEN NAME

Ellen Broncheau

MOTHER

RESIDENCE

Caldese Ids

RESIDENCE

Caldese Ids

COLOR

Indian

AGE AT LAST BIRTHDAY

50
(Years)

COLOR

Indian

AGE AT LAST BIRTHDAY

29
(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Idaho

OCCUPATION

Common Laborer

OCCUPATION

HousewifeNumber of child of this mother, including present birth 1Number of children of this mother now living, including present birth none

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE *

I hereby certify that I attended the birth of this child, who was Stillborn, at 4:45 P. M. on the date above stated.
(Born alive or stillborn)

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

George Gagnard
Physician
(Physician or midwife)

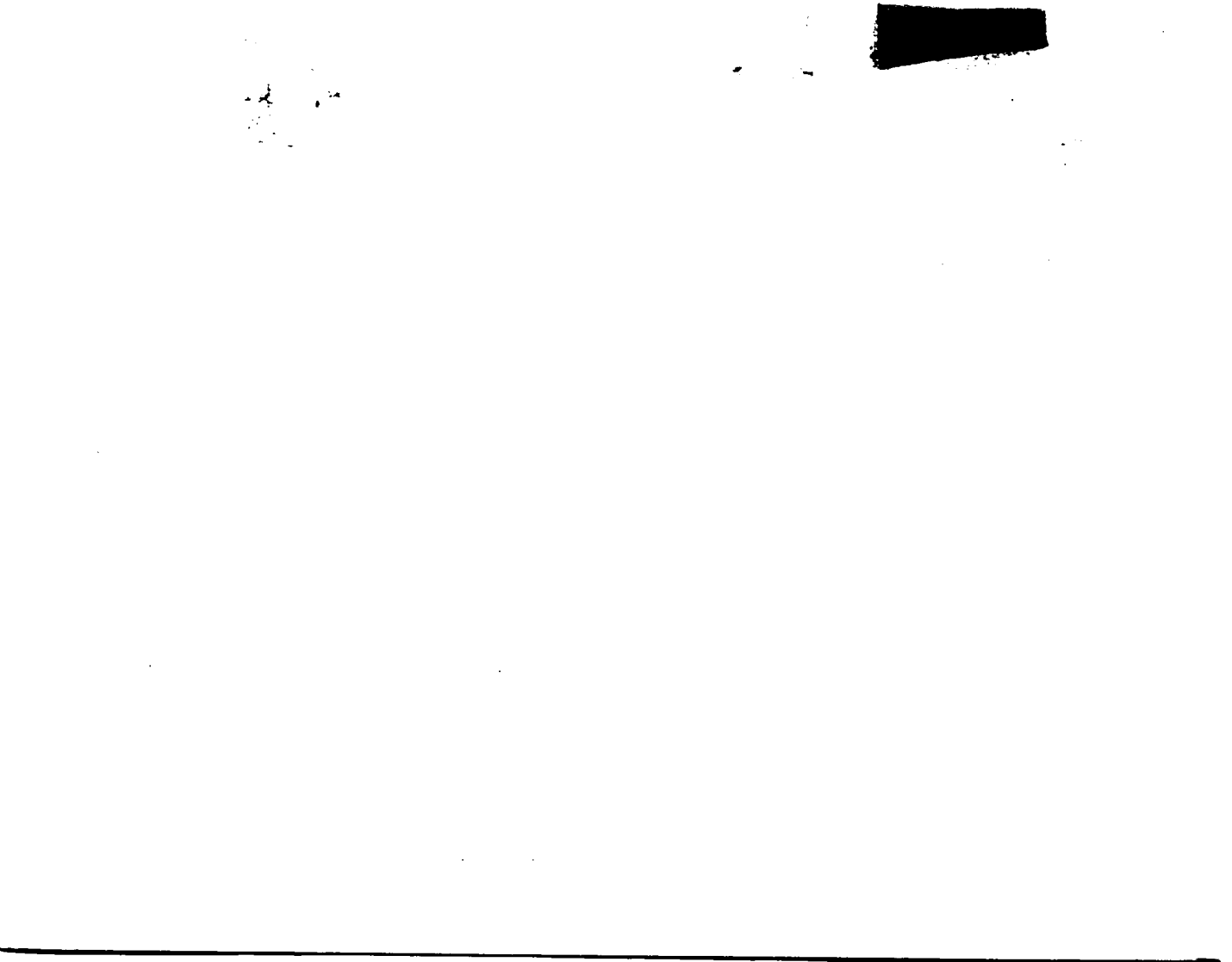
Given names added from a supplemental report.

Address

Caldese Ids

Filed

March 24 George Gagnard
Registrar



1. PLACE OF DEATH

County *Key Pierce*
 City of *near Cledusa Idaho*

Registration District No. *128*Primary Registration District No. *128*(No. *128* St.)

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Stillborn Lawrence

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. *46212*

Registered No.

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

*Indian*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Single*
(Write the word.)

6. DATE OF BIRTH

March 6 1924
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country) *Idaho*10. NAME OF
FATHER*Oliver Lawrence*11. BIRTHPLACE
OF FATHER(State or Country) *Idaho*12. MAIDEN NAME
OF MOTHER*Ellen Broncheau*13. BIRTHPLACE
OF MOTHER(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Oliver Lawrence*(Address) *Cledusa Idaho*

15.

Filed *March 19 24* *George Gignard*
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 6 24
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 6 - 1924, to *19*

that I last saw him alive on *19*and that death occurred on the date stated above, at *4:45 P.M.*

The CAUSE OF DEATH* was as follows:

Stillborn

..... (Duration) Yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) *George Gignard* M. D.

March 9 24 Address

*State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

3-7-1924

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

286116-035-235

PLACE OF BIRTH

Form V. S. No. 11-C-25m-9-8-15

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 123308

County of Nez PerceCity of Caldwell IdahoRegistration District No. 128

File No. _____

No. _____ St. _____

Primary Registration District No. Caldwell

Registered No. _____

Hospital _____

FULL NAME OF CHILD Stillborn Shores

Sex of Child

MaleTwin
Triplet
or other?{ and } Number
in order
of birthLegiti-
mate?yes

Date of Birth

3 16 1924
(Month) (Day) (Year)

FULL NAME

William A. Shores

FATHER

FULL MAIDEN NAME

Maytha Stewart

MOTHER

RESIDENCE

Caldwell Idaho

RESIDENCE

Caldwell Idaho

COLOR

White

AGE AT LAST BIRTHDAY

27
(Years)

COLOR

White

AGE AT LAST BIRTHDAY

23
(Years)

BIRTHPLACE

Oklahoma

BIRTHPLACE

Idaho

OCCUPATION

Blacksmith

OCCUPATION

HousewifeNumber of child of this mother, including present birth 3Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE *

I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated.

(Born alive or stillborn)

9:30 P. M.

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

George Guignard
Physician

(Physician or midwife)

Given names added from a supplemental report.

Address

Caldwell Idaho

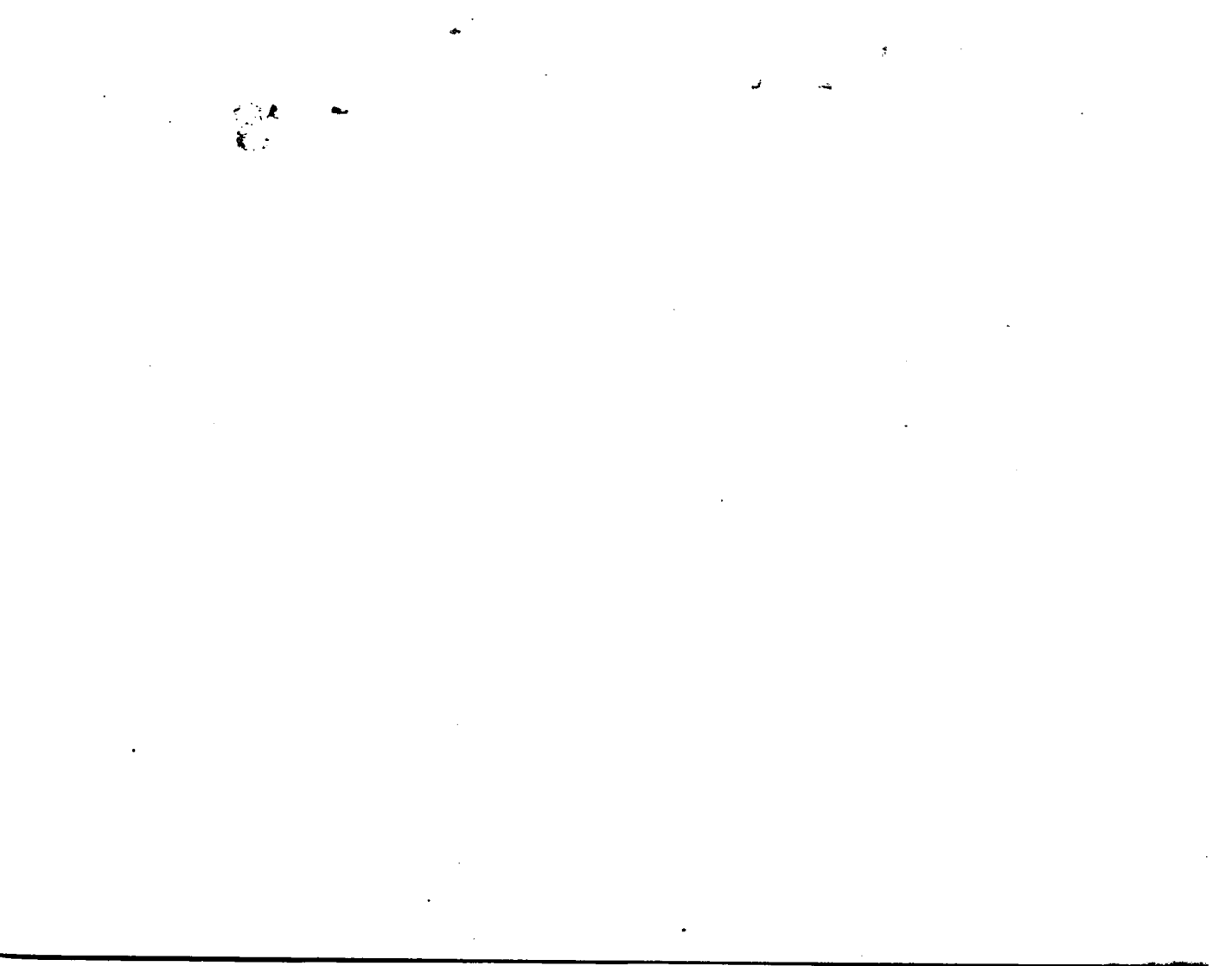
Filed

March 24 George Guignard
Registrar

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

MARGIN RESERVED FOR BINDING



CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Nez Perce*City of *Caldwell Ida*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *128*Primary Registration District No. *Caldwell*

(No. & Vicinity) St.)

File No. *16213*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Stillborn Shores

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

March 16 1924
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

William R. Shores

11. BIRTHPLACE OF FATHER

(State or Country) *Oklahoma*

12. MAIDEN NAME OF MOTHER

Martha Stewart

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *William R. Shores*(Address) *Caldwell Idaho*

15.

Filed *March 24 1924* *George Gaignard*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 16 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 16 1924 to *19*that I last saw him alive on *19*and that death occurred on the date stated above, at *9:30 P.M.*

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *George Gaignard* M. D.*March 24* (Address) *Caldwell Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Caldwell Idaho 3-17 1924

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*; (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name or gin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO		DEPARTMENT OF PUBLIC WELFARE		BUREAU OF VITAL STATISTICS		S	
279 126-035-866		RECEIVED		JUL 5 1924		BUREAU OF VITAL STATISTICS		CERTIFICATE OF BIRTH 23335	
County of <u>Nezperce</u>		City of <u>Gifford</u>		Registration District No. <u>92</u>		File No. <u>11</u>			
Hospital		Primary Registration District No. <u>2170</u>		Registered No. <u>3</u>					
FULL NAME OF CHILD		Stillborn							
(Certificate of no value without full name of child.)									
Sex of Child <u>male</u>	Twin <u>Triplet</u> or other <u>—</u>	and <u>—</u> in order of birth	Number <u>—</u> of birth	Legitimate <u>Yes</u>	Date of birth <u>June 26</u>	<u>1924</u>		<u>4</u>	
(To be answered only in event of plural births)				(Month) (Day) (Year)					
What bactericidal solution was used in eyes? <u>—</u>									
Number of child of this mother, including present birth <u>1</u>					Number of child of this mother now living, including present birth <u>0</u>				
FULL NAME <u>Edward Wesley Spindler</u>					FULL MAIDEN NAME <u>Ruby Irene Nowerton</u>				
RESIDENCE <u>Gifford Idaho Star route</u>					RESIDENCE <u>Gifford Star Route</u>				
COLOR <u>white</u>		AGE AT LAST BIRTHDAY <u>23</u>		COLOR <u>white</u>		AGE AT LAST BIRTHDAY <u>18</u>			
		(Years)				(Years)			
BIRTHPLACE <u>Iowa</u>					BIRTHPLACE <u>Craigmont Idaho</u>				
OCCUPATION <u>Rancher</u>					OCCUPATION <u>Housewife</u>				
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*									
I hereby certify that I attended the birth of this child, who was <u>stillborn</u> , at <u>10:05 A.</u> M. on the date above stated. (Born alive or stillborn)									
{ *When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }					(Signature) <u>J. E. Duclap M.D.</u>				
					(Physician or midwife)				
Give names added from a supplemental report.					Address <u>Craigmont Idaho</u>				
					Filed <u>6-27</u> 192 <u>4</u> <u>E. E. Watts</u>				
					Registrar.				

8

1000

1000

1000

1000

1000

1000

1000

1000

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH
Nezperce

County of _____

City of **Gifford Star route**

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. _____

Primary Registration District No. **2170**

(No. _____ St.)

46210

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. _____

Local Registrar's No. **24**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **Stillborn**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

single

(Write the word)

6. DATE OF BIRTH

n June 26

1924

1924

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1
day how many

hrs. or

min.?

Yrs.

Mos.

ds.

8. OCCUPATION

(a) Trade, profession or
particular kind of work

infant

(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country)

Gifford Star route

10. NAME OF
Father

Edwar Wesley Spindler

11. BIRTHPLACE
OF FATHER

Iowa

(State or Country)

12. MAIDEN NAME
OF MOTHER

Ruby Irene Nowerton

13. BIRTHPLACE
OF MOTHER

Craigmont Idaho

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. W. Spindler

(Address) **Gifford Star route**

15.

Filed

6-27

1924

E. E. Watts

Over

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 26

(Month)

(Day)

1924

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
June 26 **1924** to **June 26** **1924**,
never in

that I last saw him alive on _____ 19____,

and that death occurred on the date stated above, at **10:05 A**

The CAUSE OF DEATH* was as follows:

Stillborn

see other side for cause

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

6/26 (Signed) **RE. E. Watts**

M. D.
19____ (Address) **Craigmont Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Lookout Ida

DATE OF BURIAL

6-27 1924

20. UNDERTAKER

None

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

240

Cause of stillbirth probably as follows; mother has had pyelitis of pregnancy for 6 months and was thin, febrile and emaciated. Labour induced. Signs 2 days before birth; Labor induced.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

993-121-040-217
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Shoshone RECEIVED JUL 8 1924
City of Emaville
No. _____ St. _____ Registration District No. 153 File No. 123415
Hospital _____ Primary Registration District No. _____ Registered No. 33
FULL NAME OF CHILD Stillborn Richards

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? _____ } and { Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>3-31-1924</u> (Month) (Day) (Year)
--------------------------	--	------------------------	--

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth _____ Number of child of this mother now living, including present birth _____

FATHER		MOTHER	
FULL NAME	<u>Alfred Richards</u>	FULL MAIDEN NAME	<u>Ruth Seger</u>
RESIDENCE	<u>Emaville</u>	RESIDENCE	<u>Emaville Idaho</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>24</u> (Years)	AGE AT LAST BIRTHDAY	<u>19</u> (Years)
BIRTHPLACE	<u>Idaho</u>	BIRTHPLACE	<u>Iowa</u>
OCCUPATION	<u>Forest Ranger</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3 P M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. C. Linsley
Physician
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____
_____, 19____
Registrar.

Address Kellogg Idaho
Filed 6/19 1924 E. E. Hardy
Registrar.

2

PLACE OF BIRTH



Registration Form

NAME OF CHILD

DATE OF BIRTH

PLACE OF BIRTH

SEX

RELIGION

EDUCATION

PROFESSION

RESIDENCE

DATE OF REGISTRATION

SIGNATURE OF REGISTRAR

STAMP OF REGISTRAR

STAMP OF OFFICE

STAMP OF DISTRICT

STAMP OF PROVINCE

STAMP OF UNION

STAMP OF COUNTRY

REGISTRATION OF BIRTH

1. The Registrar shall register the birth of every child born in the district.

2. The Registrar shall register the birth of every child born in the district who is the child of a person who is a resident of the district.

3. The Registrar shall register the birth of every child born in the district who is the child of a person who is a resident of the district.

4. The Registrar shall register the birth of every child born in the district who is the child of a person who is a resident of the district.

5. The Registrar shall register the birth of every child born in the district who is the child of a person who is a resident of the district.

6. The Registrar shall register the birth of every child born in the district who is the child of a person who is a resident of the district.

7. The Registrar shall register the birth of every child born in the district who is the child of a person who is a resident of the district.

8. The Registrar shall register the birth of every child born in the district who is the child of a person who is a resident of the district.

9. The Registrar shall register the birth of every child born in the district who is the child of a person who is a resident of the district.

10. The Registrar shall register the birth of every child born in the district who is the child of a person who is a resident of the district.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho JUL 17 1923

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth	(CITY <u>Kellogg</u>	FILE NO. <u>123415</u>
	(ST. _____	DATE OF BIRTH <u>March 21</u>
	(COUNTY _____	SEX OF CHILD <u>Male</u> <i>female</i>
FATHER <u>Agnes Richards</u>		MOTHER <u>Ruth Leger</u> (MAYDEN NAME)

I HEREBY CERTIFY that the child herein described has been named:

Has still Born

Mrs Agnes Richards
Signature of Father or Mother.

the same time, the *Journal of the American Medical Association* (JAMA) published a series of articles that highlighted the importance of medical research in improving patient care. These articles, which were part of a larger effort to promote medical research, emphasized the need for a more systematic approach to medical research. One of the key figures in this movement was the physician and researcher, who had been instrumental in the development of the *Journal of the American Medical Association*. His work, which had been published in the *Journal of the American Medical Association*, had shown that medical research could be used to improve patient care. This work, which had been published in the *Journal of the American Medical Association*, had shown that medical research could be used to improve patient care. This work, which had been published in the *Journal of the American Medical Association*, had shown that medical research could be used to improve patient care.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Shoshone*
City of *Kellogg*Registration District No. *123*

Primary Registration District No. _____

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Baby Richards*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *5005*Registered No. *19*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

March
(Month)*3*
(Day)*1924*
(Year)

7. AGE

____ Yrs. ____ Mos. ____ ds.

IF LESS than 1 day
how many ____ hrs.
or ____ min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
-
- (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

A. H. Richards

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Ruth Jager

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. H. Richards

(Address)

Emerville, Idaho

15. Filed

*4/3/24**19**E. E. Hard*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March
(Month)*3*
(Day)*1924*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

____ 19____, to ____ 19____

that I last saw him ____ alive on ____ 19____

and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Breech presentation at birth resulting in strangulation & still birth

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory
(Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

W. E. Lacey

M. D.

3/29 1924(Address) *Kellogg Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Greenwood

DATE OF BURIAL

March 1924

20. UNDERTAKER

McNabb

ADDRESS

Kellogg, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

368-712 240-551
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Shoshone JUL 3 1924
City of Kellogg
No. _____ St. _____ Registration District No. 133 File No. 23426
Hospital _____ Primary Registration District No. _____ Registered No. 44
FULL NAME OF CHILD (Child) Collins
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? _____ and Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>5-12-1924</u> (Month) (Day) (Year)
--------------------------	--	------------------------	--

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME <u>John Collins</u>	FULL MAIDEN NAME <u>Hannah Evans</u>		
RESIDENCE <u>Kellogg</u>	RESIDENCE <u>Kellogg Idaho</u>		
COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>49</u> (Years)	COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>37</u> (Years)		
BIRTHPLACE <u>Kansas</u>	BIRTHPLACE <u>Wales</u>		
OCCUPATION <u>Labour</u>	OCCUPATION <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Edw. Born at 12 a M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) H. E. Hard
Physician
(Physician or midwife)

Give names added from a supplemental report.

Address Kellogg Idaho
Filed 6/19/1924 E. E. Hard
Registrar

2

DEPT. OF
HUR.

1800-1810

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho _____

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY _____
(ST. _____
(COUNTY _____
27. 24
FATHER _____

FILE NO. 123426
DATE OF BIRTH _____
SEX OF CHILD Male
MOTHER _____

(MAIDEN NAME)

I HEREBY CERTIFY that the child herein described has been named:

*Baby only lived just a few
yrs. when born
it wasn't named*
John Ballin
Signature of Father or Mother.



[The main body of the page contains extremely faint, illegible text, likely due to the quality of the scan or the nature of the document. The text is scattered across the page, with some lines appearing more distinct than others. There are also some dark, horizontal marks that could be remnants of lines or redactions.]

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Shoshone*City of *Heppner*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *123*Primary Registration District No. *3*(No. *3*)

St.)

File No. *46332*Registered No. *22*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Bobby Collins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

none

9. BIRTHPLACE

(State or Country)

Shoshone, Idaho

10. NAME OF FATHER

J. F. Collins

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Anna J. Evans

13. BIRTHPLACE OF MOTHER

(State or Country)

Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B. F. Collins

(Address)

Heppner, Idaho

15.

Filed

6/19/20 E. E. Hardy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 13, 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....

that I last saw him alive on19.....

and that death occurred on the date stated above, atM.

The CAUSE OF DEATH* was as follows:

Stroke

.....(Duration)Yrs.mos.ds.

Contributory
(Secondary)

.....(Duration)Yrs.mos.ds.

(Signed) *W. L. Lindsay* M. D.*W. L. Lindsay*
1924 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of deathyrs.mos.days. In the Stateyrs.mos.days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Heppner, Idaho

DATE OF BURIAL

May 13, 1924

20. UNDERTAKER

McHardy

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

579213040' 218

PLACE OF BIRTH

RECEIVED

JUL 8 1924

BUREAU OF VITAL STATISTICS

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-20m-2-15-12

S

CERTIFICATE OF BIRTH

123427

County of ShoshoneCity of KelloggNo. 1 St. St.Registration District No. 123

File No.

Primary Registration District No.

Registered No. 45

Hospital

FULL NAME OF CHILD

Poland Parker

Sex of Child <u>female</u>	Twin Triplet or other? <u>and</u> Number in order of birth <u>1</u>	Legitimacy? <u>yes</u>	Date of Birth <u>5-13-20</u> (Month) (Day) (Year)
----------------------------	---	------------------------	--

FULL NAME <u>Angela Marie Parker</u>	FATHER	FULL MAIDEN NAME <u>Paula Marie Bayless</u>	MOTHER
--------------------------------------	--------	---	--------

RESIDENCE <u>Kellogg Idaho</u>	RESIDENCE <u>Kellogg Idaho</u>
--------------------------------	--------------------------------

COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>31</u> (Years)
--------------------	---	--------------------	---

BIRTHPLACE <u>Cambridge England</u>	BIRTHPLACE <u>Oxford England</u>
-------------------------------------	----------------------------------

OCCUPATION <u>Teacher in Miss Mary</u>	OCCUPATION <u>Housewife</u>
--	-----------------------------

Number of child of this mother, including present birth <u>4</u>	Number of children of this mother now living, including present birth <u>3</u>
--	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was still born at 6:30 P.M. on the date above stated.
(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

E. E. Hardy M.D.

(Physician or midwife)

Given names added from a supplemental report

Address

Kellogg Idaho

Filed

6/19/24

Registrar

Registrar

2

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho _____

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

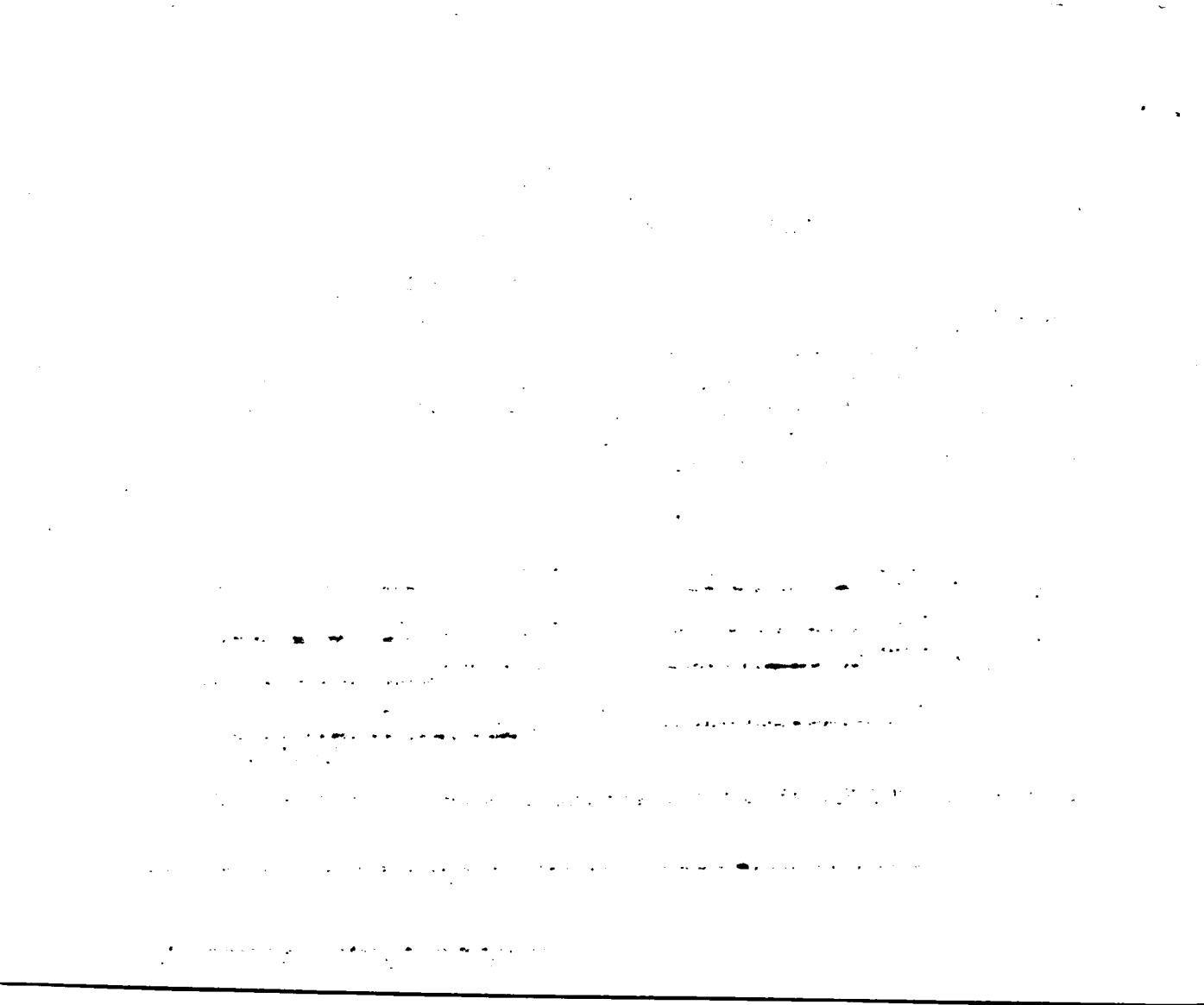
* * * * *

Place of Birth (CITY Kellogg FILE NO. 123427
(ST. Idaho DATE OF BIRTH May 13th 1924
(COUNTY Shoshone SEX OF CHILD Female
FATHER Hugh Price Varker MOTHER Rulah Beatrice Bayliss
(MAIDEN NAME)

I HEREBY CERTIFY that the child herein described has been named:

Roland Varker

Hugh Price Varker
Signature of Father or Mother.



PLAC

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

123605

County of Blaine
 City of Lava Hot Springs
 No. 696-103.003-214 St. Registration District No. 84 File No. _____
 Hospital _____ Primary Registration District No. 276 Registered No. 80
 FULL NAME OF CHILD Wallace Leon Fife *

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>6-3-1924</u> (Month) (Day) (Year)
--------------------------	------------------------------	-----------	--------------------------------	------------------------	---

What bacteriocidal solution was used in eyes? arg. i. p. p. 10%Number of child of this mother, including present birth 1Number of child of this mother now living, including present birth 0FATHER
FULL NAME Leon Leroy FifeMOTHER
FULL MAIDEN NAME Stella Florence BauerRESIDENCE Lava Hot SpringsRESIDENCE Lava Hot SpringsCOLOR WhiteAGE AT LAST BIRTHDAY 23
(Years)COLOR WhiteAGE AT LAST BIRTHDAY 22
(Years)BIRTHPLACE Logan, UtahBIRTHPLACE Nashville, TennOCCUPATION MechanicOCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____ on the date above stated.

(Born alive or stillborn) 11 25 A. M.

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

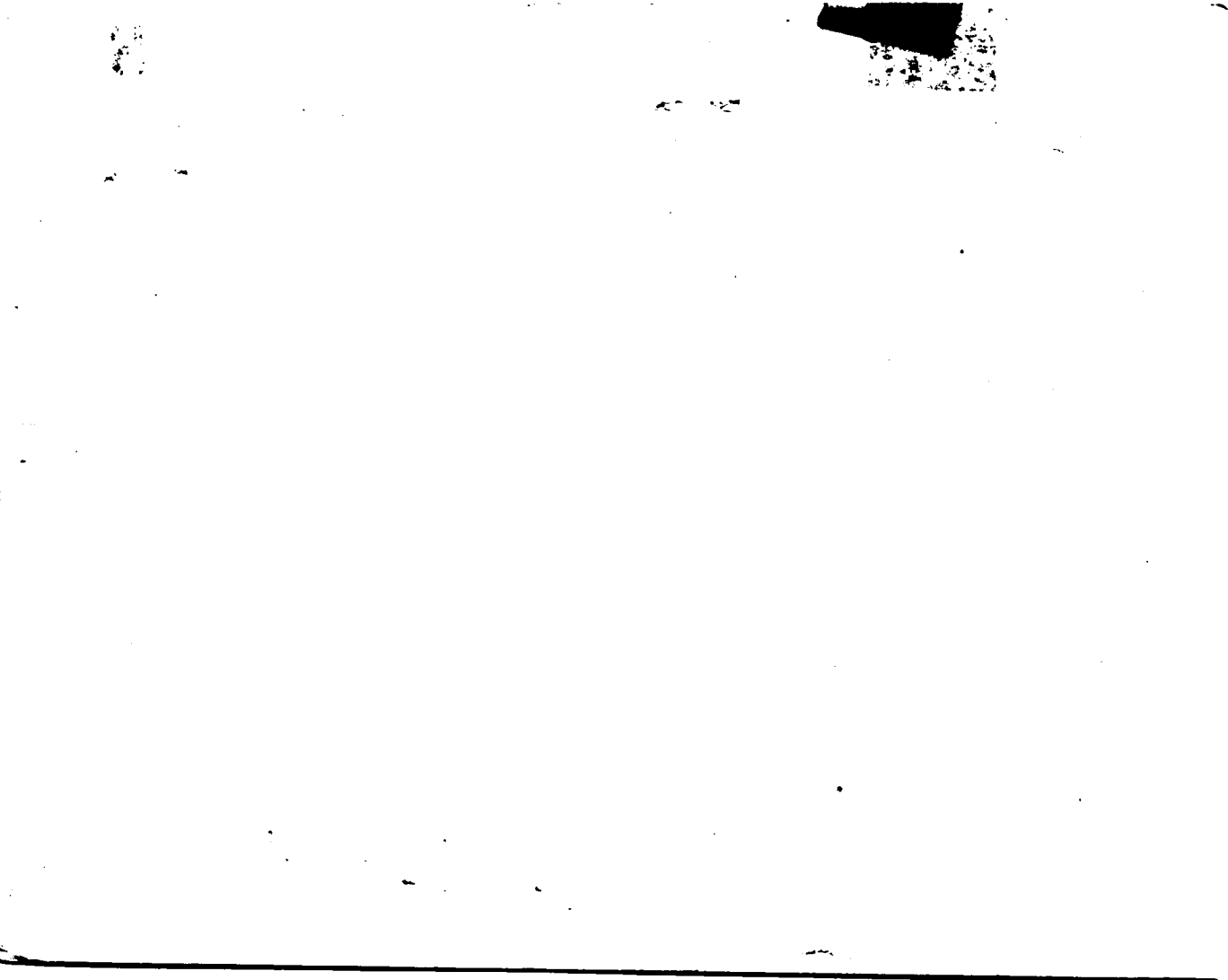
(Signature) T. W. Hinesworth

Give names added from a supplemental report.

Address Lava Hot Springs, IdaFiled Aug-1-1924

Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

47230

1. PLACE OF DEATH

County of Bannock
City of Lava Hot SpgsRegistration District No. 84Suburban Registration District No. 2161(No. 84 St.)State File No. 22Local Registrar's No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wallace Leon Fife

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single
(Write the word)

6. DATE OF BIRTH

6 - 3 - 1924
(Month) (Day) (Year)

7. AGE

Still Born
Yrs. Full 9 Mo term ds. 9 hrs. or min. ?
IF LESS than 1 day how many

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)9. BIRTHPLACE
(State or Country)Bannock

10. NAME OF Father

Leon Leroy Fife

11. BIRTHPLACE OF FATHER

Logan Utah

12. MAIDEN NAME OF MOTHER

Stella Florence Bauer

13. BIRTHPLACE OF MOTHER

Madison Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Stella Bauer Fife

(Address)

Lava Hot Springs

15.

Filed Nov 1 -1924Mrs. G. F. Fife

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

6 - 3 - 1924
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 19 to 19,that I last saw him alive on 19,
and that death occurred on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Still Born
Full 9 Mo term
(Duration) yrs. mos. ds.Contributory
(Secondary)(Signed) J. H. Hightworth M. D.19 (Address) Lava Hot Springs

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Lava Hot Spgs. Ida.

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

433-119 003 995
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED
AUG 4 1924
BUREAU OF VITAL STATISTICS

S
123613

County of Bainbridge
City of London
No. _____ St. _____
Hospital _____
Primary Registration District No. 2161
Registered No. 88
FULL NAME OF CHILD Baty McClelland
(Certificate of no value without full name of child.)

Sex of Child Male Twin Triplet or other? _____ and _____ Number in order of birth _____ Legitimate? Yes Date of birth 7-19-1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Nitrate of Silver
Number of child of this mother, including present birth. 1 Number of child of this mother now living, including present birth. 1

FATHER
FULL NAME James McClelland
RESIDENCE Tonopze
COLOR White AGE AT LAST BIRTHDAY 28
(Years)
BIRTHPLACE Idaho
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Rose Pauline Rindlishbacher
RESIDENCE Tonopze
COLOR White AGE AT LAST BIRTHDAY 22
(Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at _____ P. M.
on the date above stated. (Born alive or stillborn)

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. G. Fitz
Physician
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address Banner, Ida
Filed Aug 1-1924 Mrs E. G. Fitz
Registrar.

2

1941

1. PLACE OF DEATH

County of *Bannock*
City of *Laramie*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. *84*
Primary Registration District No. *2161*State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *46388*
Registered No. *16*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male *White* *Single* (Write the word.)

6. DATE OF BIRTH

July *19* *1924*
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

James McClelland

11. BIRTHPLACE OF FATHER

(State or Country) *Idaho*

12. MAIDEN NAME OF MOTHER

Rose Pauline Kindbuck

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Rose Pauline Kindbuck*(Address) *Idaho*

15.

Filed *Aug-1* *1924* *Mrs. E. F. Fitt*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July *19* *1924*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to *19*that I last saw h. *alive* on *19*and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Unknown, Stillborn(Duration) *Yrs.* *mos.* *ds.*

Contributory (Secondary)

(Duration) *Yrs.* *mos.* *ds.*(Signed) *E. E. Fitt* M. D.*7/19/1924* (Address) *Bannock Co. Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *Yrs.* *mos.* *days.* In the State *Yrs.* *mos.* *days.*

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho *Idaho*

20. UNDERTAKER

Had none ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

389-130-006 364
PLACE OF BIRTHCounty of BinghamCity of BlackfootNo. RD # 3 St.

Hospital _____

FULL NAME OF CHILD _____

Registration District No. 121Primary Registration District No. 2194

File No. _____

Registered No. 222STATE OF IDAHO
Bureau of Vital Statistics
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-16a-8-7-11

S

123628

Sex of Child <u>Male</u>	Twin, Triplet or other? _____	and	Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>July 30</u> 19 <u>24</u> (Month) (Day) (Year)
--------------------------	-------------------------------	-----	--------------------------------	------------------------	---

FATHER FULL NAME <u>Nephi Christensen</u>	MOTHER FULL MAIDEN NAME <u>Laura Lorentzen</u>
RESIDENCE <u>Blackfoot</u>	RESIDENCE <u>Blackfoot</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>43</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>42</u> (Years)
BIRTHPLACE <u>Utah</u>	BIRTHPLACE <u>Norway</u>
OCCUPATION <u>Farming</u>	OCCUPATION <u>Housewife</u>

Number of child of this mother, including present birth 9Number of children, of this mother, now living, including present birth 8

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report

(Signature) W. W. Beck at 10 P M.

(Physician or midwife)
Address Blackfoot, Ida
Aug 5, 1924
Filed for M. E. Patrice
Registrar

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of CanyonCity of NampaNo. 361-207014-949 St.Registration District No. 7State File No. 123696

Hospital

Primary Registration District No. 1006Local Registrar's No. 21FULL NAME OF CHILD Stillborn Rosemary Cooley

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Aug. 7, 1924</u>
(To be answered only in event of plural births)				(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth <u>4</u>		Number of child of this mother now living, including present birth <u>3</u>	
FATHER	MOTHER	FATHER	MOTHER
FULL NAME <u>Archibald Burns Cooley</u>	FULL MAIDEN NAME <u>Lucy Muir Cooley</u>	FULL NAME <u>Archibald Burns Cooley</u>	FULL MAIDEN NAME <u>Lucy Muir Cooley</u>
RESIDENCE <u>Shoshone Falls, Mont.</u>	RESIDENCE <u>Nampa</u>	RESIDENCE <u>Shoshone Falls, Mont.</u>	RESIDENCE <u>Nampa</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>43</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>43</u> (Years)
BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Idaho</u>
OCCUPATION <u>Labourer</u>	OCCUPATION <u>Labourer</u>	OCCUPATION <u>Labourer</u>	OCCUPATION <u>Labourer</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3:30 A.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) M. BroadbentM. L. Frick M.D.

(Physician or midwife)

Address Nampa, Ida.Filed Aug 1 1924 Mae Kerby

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. R.--in case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

UNION TERRITORY OF ALASKA
 DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

PLACE OF BIRTH

DEPARTMENT OF PUBLIC HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

134886

2

No. 134886 Registration District No. 1000
 Hospital St. Mary's Primary Health District No. 1000 Local Registrar's No. 1000

FULL NAME OF CHILD John Doe
 (Certificate of no alias without full name of child)
 Sex of Child Male Date of Birth Jan 1 1900
 (To be answered only in event of plural births)
 (Month) (Day) (Year)

What bacteriological examination was made in event?
 Number of child of this mother, including present birth
 Number of child of this mother now living, including present birth

FATHER	MOTHER
FULL NAME	FULL NAME
RESIDENCE	RESIDENCE
COLOR	COLOR
AGE AT LAST BIRTHDAY (Years)	AGE AT LAST BIRTHDAY (Years)
BIRTHPLACE	BIRTHPLACE
OCCUPATION	OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child who was born on the date above stated. Date when at

(Signature) _____
 (Physician or midwife)
 Address _____
 Filed _____
 Registrar _____

*When there was no attending physician or midwife, then the father, mother, or grandparent make this return. A birth record is one that neither provides nor shows other evidence of the child's birth.
 Give names added from a supplementary report.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 46430
Registered No. _____

1. PLACE OF DEATH

County Lamson
City of Nampa

Registration District No. _____

Primary Registration District No. 2006

(No. _____ St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Rosemary Cooley

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

May 7 1924
(Month) (Day) (Year)

7. AGE

✓ Yrs. ✓ Mos. ✓ ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF
FATHER

A. B. Cooley

11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME
OF MOTHER

Fanny Miller

13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. A. B. Cooley

(Address) Nampa, Ida

15.

Filled Aug 1 1924 Mac Kerby
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5 7 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 7 1924, to May 7 1924,
that I last saw her alive on May 7 1924,
and that death occurred on the date stated above, at 3:40 PM.

The CAUSE OF DEATH* was as follows:

Splanteric asphyxia

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

Marion J. Tink M.D.
Aug 1 1924 (Address) Nampa, Ida

(State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.)

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted
if not at place of death?

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Red Lodge, Mont 5/8 1924

20. UNDERTAKER

ADDRESS

F. R. Peterson Nampa

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Cassia
City of Burley
No. 249-125016-692 St. Registration District No. 117 State File No. 123728
Hospital _____ Primary Registration District No. 2196 Local Registrar's No. 2902
FULL NAME OF CHILD *Stillborn Smith

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? } and { Number in order of birth ✓ Legitimate? yes Date of birth July 25 - 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth. 6 Number of child of this mother now living, including present birth. 1

FATHER
FULL NAME Fred. Smith
RESIDENCE Burley, Idaho
COLOR white AGE AT LAST BIRTHDAY 40
(Years)
BIRTHPLACE Millard Co. Idaho
OCCUPATION Labourer

MOTHER
FULL MAIDEN NAME Mabel Fisher
RESIDENCE Burley, Idaho
COLOR white AGE AT LAST BIRTHDAY 41
(Years)
BIRTHPLACE Salt Lake Co. Utah
OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 10 a.m.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) G. H. Cooper
Physician
(Physician or midwife)

Address Burley, Idaho
Filed 8-8-24 192 Dr. J. C. Patterson

Registrar.

Registrar.

RECEIVED BY THE BUREAU OF VITAL STATISTICS
 COUNTY OF ...
 CITY OF ...
 DATE OF RECEIPT ...
 BY ...

PLACE OF BIRTH

STATE OF TEXAS
 DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

2

County of _____ City of _____
 No. _____
 Date of Birth _____
 Sex of Child _____
 Full Name of Child _____
 (Certificate of no value without full name of child)
 Date of Birth _____
 Sex of Child _____
 (Certificate of no value without full name of child)

What bacteriological solution was used in every _____
 Number of child of this mother, including present birth _____
 Number of children this mother now living, including present birth _____
 FATHER FULL NAME _____
 RESIDENCE _____
 COLOR _____
 AGE AT LAST BIRTHDAY _____
 BIRTHPLACE _____
 OCCUPATION _____
 MOTHER FULL NAME _____
 RESIDENCE _____
 COLOR _____
 AGE AT LAST BIRTHDAY _____
 BIRTHPLACE _____
 OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who was _____
 born at _____
 on the _____ day of _____, 19____
 and that there was no attending physician or midwife then in the room.
 The above is the true and correct statement of the facts as they occurred.
 (Signature) _____
 Address _____
 Filed _____
 Registered _____

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 46555
Registered No. 728

1. PLACE OF DEATH

County of Cassia
City of Burley

Registration District No. 117
Primary Registration District No. 2196
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Male White Single
(write the word.)

6. DATE OF BIRTH

July 25 1924
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.

IF LESS than 1 day
how many ☒ hrs.
or ☐ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Burley, Ida.

10. NAME OF FATHER

Fred Smith

11. BIRTHPLACE OF FATHER

(State or Country) Millard Co. Utah.

12. MAIDEN NAME OF MOTHER

Mabel Fisher

13. BIRTHPLACE OF MOTHER

(State or Country) Salt Lake Co. Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 8-8 1924 H. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 24 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Born 19 Dead 19

that I last saw him alive on 19

and that death occurred on the date stated above, at 7 M.

The CAUSE OF DEATH* was as follows:

Condition of mother
Probably, stillborn

(Duration) Stillborn Yrs. mos. ds.

Contributory (Secondary)

(Duration) 1 yrs. mos. ds.

(Signed) B. H. Cooper M. D.

7-24-1924 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley, Ida. July 24, 1924

20. UNDERTAKER

None

DATE OF BURIAL

ADDRESS

Burley, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

County of SevierCity of ClaytonNo. 419-101-089000 St.Registration District No. 108State File No. S 123742Hospital..... Primary Registration District No. 2186 Local Registrar's No. 18FULL NAME OF CHILD Not named

(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin <u>Sum</u> Triplet or other?	and { Number in order of birth 1	Legitimate? <u>yes</u>	Date of Birth <u>7/1/1924</u> (Month) (Day) (Year)
-----------------------	---	---	------------------------	---

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER FULL NAME <u>Andrew Maraffio</u>
RESIDENCE <u>Clayton Ida</u>
COLOR <u>Wh</u> AGE AT LAST BIRTHDAY <u>30</u> (Years)
BIRTHPLACE <u>Italy</u>
OCCUPATION <u>Farmer</u>

MOTHER FULL MAIDEN NAME
RESIDENCE <u>Clayton Ida</u>
COLOR <u>Wh</u> AGE AT LAST BIRTHDAY <u>30</u> (Years)
BIRTHPLACE <u>Italy</u>
OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive
Stillborn } at Clayton Ida on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. V. Kirtley M.D.
(Physician or midwife)

Give names added from a supplemental report.

Address.....
Filed Aug 1 1924 Hazel Jones
Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JANUARY 21 1917
 DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS
 DIVISION OF RECORDS
 PHILADELPHIA, PA.

PLACE OF BIRTH

DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS
 DIVISION OF RECORDS

County of _____
 City of _____
 No. _____
 Registered _____
 Primary Registration District No. _____

NAME OF CHILD

(Certificate of marriage without full name of child)

Box of Child	Sex of Child	Color of Child	Weight of Child	Length of Child	Head of Child	Feet of Child
(To be answered only in event of birth)						

What particular collection was used in case?

Number of child of this mother, including present birth _____
 Number of child of this mother, including present birth _____

FATHER	MOTHER
FULL NAME	FULL NAME
RESIDENCE	RESIDENCE

DATE AT BIRTH	DATE AT BIRTH
(Year)	(Year)

BIRTHPLACE	BIRTHPLACE
OCCUPATION	OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
 on the date above stated.

When there was no attending physician or midwife, then the father, mother, or other person should make this return. A physician or midwife is not required to sign this certificate.

Address _____
 Date _____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Butte*
City of *Clayton*

CERTIFICATE OF DEATH

Registration District No. *108*
BUREAU OF Registration District No. *2186*
(STATIST) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

not named

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *46442*
Local Registrar's No. *9*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

wh

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

July 1 1924
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Clayton, Ida

10. NAME OF
Father

Andrew Maraffio

11. BIRTHPLACE
OF FATHER

(State or Country)

Italy

12. MAIDEN NAME
OF MOTHER

13. BIRTHPLACE
OF MOTHER

(State or Country)

Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *Aug 1*

1924

Hazel Jones
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 1 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw h. alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still born. First born of twins
(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. H. H. H.

M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

669-226-020-293

County of *Elmore*City of *Elmer's Ferry*

No. _____

Registration District No. *35*

File No.

123748

Hospital _____

Primary Registration District No. *2021*

Registered No. _____

FULL NAME OF CHILD

Unnamed (Stillborn)

(Certificate of no value without full name of child.)

Sex of
Child*Female*Twin
Triplet
or other?

}

Number
in order
of birth*2*Legiti-
mate?*yes*Date of
birth... *July 26*..... 192*4*

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes? *None*Number of child of this mother, including present birth... *2*Number of children of this mother now living, including present birth... *1*FULL
NAME

FATHER

Thomas M. Forrest

RESIDENCE

Elmer's Ferry Idaho

COLOR

*white*AGE AT LAST
BIRTHDAY*29*
(Years)

BIRTHPLACE

Amnicia

OCCUPATION

*Housewife*FULL
MAIDEN
NAME

MOTHER

Mary Silva

RESIDENCE

Elmer's Ferry Idaho

COLOR

*white*AGE AT LAST
BIRTHDAY*18*
(Years)

BIRTHPLACE

Amnicia

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.*July 26, 1924, at 4:45*
*Elmer's Ferry (Stillborn)**A. M.*

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

*J. W. Jones**Physician*
(Physician or midwife)

Give names added from a supplemental report.

Address

Elmer's Ferry Idaho

Filed

*July 30, 1924**J. W. Jones*

Registrar.

Registrar.

GENERAL INSTRUCTIONS TO ALL BIRTH REGISTRARS CONCERNING THE FILLING OF THIS FORM
 1. The birth record is a permanent record and should be filled out in ink.
 2. The birth record should be filled out as soon as possible after the birth.
 3. The birth record should be filled out for all births, including stillbirths and abortions.
 4. The birth record should be filled out for all children, including illegitimate children.
 5. The birth record should be filled out for all children, including children of unknown parentage.
 6. The birth record should be filled out for all children, including children of unknown sex.
 7. The birth record should be filled out for all children, including children of unknown race.
 8. The birth record should be filled out for all children, including children of unknown religion.
 9. The birth record should be filled out for all children, including children of unknown occupation.
 10. The birth record should be filled out for all children, including children of unknown residence.

CERTIFICATE OF BIRTH

153748

Registration District No. _____
 Primary Registration District No. _____
 Hospital _____

FULL NAME OF CHILD

Given Name _____
 Surname _____
 Date of Birth _____
 Sex _____
 Race _____
 Religion _____
 Occupation _____

Signature of Registrar _____
 Signature of Parent _____

Color _____
 Birthplace _____
 Occupation _____
 Religion _____
 Race _____
 Sex _____
 Date of Birth _____
 Signature of Registrar _____
 Signature of Parent _____

CERTIFICATE OF ALIEN BIRTH

Signature of Registrar _____
 Signature of Parent _____
 Date of Birth _____
 Sex _____
 Race _____
 Religion _____
 Occupation _____

Signature of Registrar _____
 Signature of Parent _____
 Date of Birth _____
 Sex _____
 Race _____
 Religion _____
 Occupation _____

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **46444**

1. PLACE OF DEATH. Registration District No. **30**
County of **Elmore** Primary Registration District No. **3031**
City of _____ (No. _____, _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unmarried

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED.

Female **White** **Single**
(Write the word.)

6. DATE OF BIRTH

July **26** **1924**
(Month) (Day) (Year)

7. AGE

Still Born

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Thomas M. Forrest

11. BIRTHPLACE OF FATHER

(State or Country)

Armenia

12. MAIDEN NAME OF MOTHER

Mary Silva

13. BIRTHPLACE OF MOTHER

(State or Country)

Armenia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Mary Forrest

(Address)

Elmore, Idaho

15.

Filed

July 26 1924

J. W. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July **26** **1924**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 26, 1924 to July 26, 1924

that I last saw him alive on **July 26, 1924**

and that death occurred on the date stated above, at **4:45 P.M.**

The CAUSE OF DEATH* was as follows:

Still born

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. W. Davis

M. D.

July 26 1924 (Address) **Elmore, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Elmore, Idaho **July 26 1924**

20. UNDERTAKER

ADDRESS

J. M. Forrest **Elmore, Idaho**

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital)," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

Form V, S. No. 11-25m-6-15-18

County of Isodung

City of Nagerambur

Registration District No.

No. _____ St. _____

Hospital

Primary Registration District No

Registered No.

Full Name of Child

SEX OF CHILD

SEX OF CHILD Female { and } Number in order of birth
Twin Triplet or other? 0 { and } of birth
(To be answered only in event of plural births)

Legitimate?

DATE OF BIRTH

**FULL
NAME**

RESIDENCE

COLOR

AGE AT LAST

BIRTHPLACE

OCCUPATION

**FULL
MAIDEN
NAME**

MOTHER

RESIDENCE

COL 95

AGE AT LAST

BIRTHPLACE

OCCUPATION

Number of child of this mother, including present birth..... **Number of children of this mother now living, including present birth.....**

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report

(Signature)

Address

Filed

Registrar

Registrant

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

PLACE OF BIRTH

File No. 123762

Registration No.

Registered No.

Registration No.

Hospital

Full Name of Child

SEX OF CHILD	DATE OF BIRTH	LEGAL NAME	FATHER	MOTHER
Male	1911	Full Name	Full Name	Full Name
Female	1911	Legal Name	Legal Name	Legal Name
Male	1911	Residence	Residence	Residence
Female	1911	Residence	Residence	Residence
Male	1911	Age at Last Birthday	Age at Last Birthday	Age at Last Birthday
Female	1911	Age at Last Birthday	Age at Last Birthday	Age at Last Birthday
Male	1911	Birthplace	Birthplace	Birthplace
Female	1911	Birthplace	Birthplace	Birthplace
Male	1911	Occupation	Occupation	Occupation
Female	1911	Occupation	Occupation	Occupation

Number of child of this mother including present birth
Number of children of this mother now living including present birth

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was (born alive or stillborn) on the date above stated.

When there was no attending physician or midwife, then the father, grand-father, etc., should make the report. A physician or midwife who has attended the mother and child should not make the report.

Given names added from a supplemental report

Address

Filed

Registered

RECEIVED CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Hooding
City of HagermanRegistration District No. 2Primary Registrar District No. 301File No. 46449Registered No. 46449

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Francis Church

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemale WhiteInfant
(Write the word.)

6. DATE OF BIRTH

June 13 1924
(Month) (Day) (Year)

7. AGE

InfantIF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Hagerman

10. NAME OF FATHER

H H Church

11. BIRTHPLACE OF FATHER

(State or Country)

Colo

12. MAIDEN NAME OF MOTHER

Francis Sears

13. BIRTHPLACE OF MOTHER

(State or Country)

Colo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H H Church

(Address)

Hagerman

15.

Filed

June 14 1924 R H Greene
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 13 - 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 13 - 1924that I last saw still born alive on June 13 - 1924
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary) 4

(Duration) Yrs. mos. ds.

(Signed) R H Greene M. D.June 14 1924 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

NoneJune 14 1924

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

814-103 028-659
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Kootenai
City of Coeur d'Alene
No. Helms & C. St. Registration District No. 30 State File No. S 123798
Hospital Home Primary Registration District No. 1051 Local Registrar's No. 1848
FULL NAME OF CHILD Clarence Junior

(Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? and Number in order of birth 1 Legitimate? yes Date of birth July 3 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Clarence E. Yadon
RESIDENCE Coeur d'Alene
COLOR Wh. AGE AT LAST BIRTHDAY 20 (Years)
BIRTHPLACE Missouri
OCCUPATION Mill worker

MOTHER
FULL MAIDEN NAME Ethel C. Farnsworth
RESIDENCE Coeur d'Alene, Ida.
COLOR Wh. AGE AT LAST BIRTHDAY 16 (Years)
BIRTHPLACE Missouri
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was (Stillborn) at 8:30 a M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) A. H. Sturges M.D.

(Physician or midwife)

Address Coeur d'Alene, Ida.

Filed Aug 1 1924 rel Clarence

Registrar.

Registrar.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Boolemai
 City of _____

If death occurs away from usual residence, give facts called for under special information.

Registration District No. _____

Primary Registration District No. 1051
 (No. _____ St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 46471
 Registered No. 1415

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Clarence, Junior Yador

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
 (Write the word.)

6. DATE OF BIRTH

July 3 1924
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Clarence E Yador

11. BIRTHPLACE OF FATHER

(State or Country)

Washington

12. MAIDEN NAME OF MOTHER

Fay E Farnsworth

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Clarence E Yador
Cornwall Avenue Idg

15.

Filled

Aug 4 1924

D. D. Drenner
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 3 1924
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 3 1924 to _____
 that I last saw h. _____ alive on _____
 and that death occurred on the date stated above, at _____ M.
 The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

Don't know

(Duration) yrs. mos. ds.

(Signed)

J. H. Sturges M. D.

7/3 1924 (Address) Cornwall Avenue Idg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cemetery

7/3 1924

20. UNDERTAKER

ADDRESS

none

—

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK. THIS IS A PERMANENT RECORD
N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

85 2-113-086-165

PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-22a-4-6-17

S

County of OneidaCity of MaladRegistration District No. 26File No. 123823No. St.Primary Registration District No. 2064Registered No. 90

Hospital

FULL NAME OF CHILD No name Still Born

Sex of Child

BoyTwin
Triplet
or other?

and

Number
in order
of birthSix

(To be answered only in event of plural births)

Legiti-
mate?yesDate of
BirthJune 131924

(Month) (Day) (Year)

FULL
NAME

FATHER

Joseph Hess

RESIDENCE

Malad

COLOR

WhiteAGE AT LAST
BIRTHDAY35

(Years)

BIRTHPLACE

Farmington Utah

OCCUPATION

FarmerFULL
MAIDEN
NAME

MOTHER

Esther Jones

RESIDENCE

COLOR

WhiteAGE AT LAST
BIRTHDAY36

(Years)

BIRTHPLACE

Malad city

OCCUPATION

General House WorkerNumber of child of this mother, including present birth Six Number of children of this mother now living, including present birth Six

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Still Born June 13 1924
on the date above stated. (Born alive or stillborn) at 3.00 P.M.

*When there was no attending physician or
midwife then the father, householder, etc., should
make this return. A stillborn child is one that
neither breathes nor shows other evidence of life
after birth.

(Signature) Mrs. Mary E. Bolingbrook

(Physician or midwife)

Given names added from a supplemental report.

Address MaladFiled 7-31-24 J. M. Kerns

Registrar

Registrar

BRITISH NO. 1 NEW PRESS MIDWINTER

BRITISH NO. 1 NEW PRESS MIDWINTER

BRITISH NO. 1 NEW PRESS MIDWINTER

PLACE OF BIRTH

County of

City of

No.

Street

THE NAME OF CHILD

Sex of

DATE

RESIDENCE

BIRTHPLACE

OCCUPATION

NUMBER OF CHILD IN THIS FAMILY, INCLUDING PRESENT BIRTH

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

born on the date stated

When the mother was in labour, I attended her

and delivered the child in good health

After birth

CERTIFICATE OF BIRTH

BUREAU OF VITAL STATISTICS

2

158888

Registration District No.

Parish or Town and District No.

Registered No.

DATE OF BIRTH

TIME

RESIDENCE

BIRTHPLACE

OCCUPATION

NUMBER OF CHILD IN THIS FAMILY, INCLUDING PRESENT BIRTH

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

born on the date stated

When the mother was in labour, I attended her

and delivered the child in good health

After birth

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of IdahoCity of VictorNo. 249-128 04-249Registration District No. 77 State File No. 123887Hospital Star Primary Registration District No. 9176 Local Registrar's No. 3FULL NAME OF CHILD It was still born no name
Leut Burtis (Certificate of no value without full name of child)Sex of Child Boy Twin Triplet or other? and Number in order of birth 1 Legitimate? yes Date of birth January 28 1924
(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth one Number of child of this mother now living, including present birth oneFATHER
FULL NAME Hyrum A Burtis
RESIDENCE Victor Idaho
COLOR White AGE AT LAST BIRTHDAY 23 (Years)
BIRTHPLACE Newton Utah
OCCUPATION FarmingMOTHER
FULL MAIDEN NAME Myral R Burcher
RESIDENCE Victor Idaho
COLOR White AGE AT LAST BIRTHDAY 18 (Years)
BIRTHPLACE Victor Idaho
OCCUPATION House Keeping

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 9.30 P. M. on the date above stated.*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.(Signature) Mrs O B Burtis
(Physician or midwife)Address Victor Idaho Box 72Filed July 10- 1924 Martha Marker Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

I hereby certify that I attended the birth of this child, who was born at
 the date above stated.
 When there was no attending physician or midwife, then the father, mother, or other person should make the report. A statement should be made that the child is one that neither presents nor shows any evidence of the above birth. The names added from a governmental report.

PLACE OF BIRTH

STATE OF MICHIGAN
 DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS

2

CERTIFICATE OF BIRTH
 153887

County of _____
 City of _____
 State File No. _____
 Registration District No. _____
 Primary Registration District No. _____
 Local Registrar's No. _____
 FULL NAME OF CHILD _____
 (Certificate of no value without full name of child)
 Sex of Child _____
 Date of Birth _____
 Month _____ Day _____ Year _____
 Legality _____
 (To be answered only in case of illegitimate child)

What bacteriological solution was used in case? _____
 Number of still of this mother, including present birth _____
 Number of child of this mother now living, including present birth _____

FULL NAME _____
 FATHER
 FULL NAME _____
 MOTHER

COLOR _____
 AGE AT LAST BIRTHDAY (7 years) _____
 COLOR _____
 AGE AT LAST BIRTHDAY

BIRTHPLACE _____
 BIRTHPLACE _____
 OCCUPATION _____
 OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who was born at _____ at _____
 (Signature) _____

Address _____
 Filed _____
 101
 (Signature of midwife) _____
 1931

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

331-204042-255
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Twin Falls

City of Twin Falls

No. 1067 Washington St.

Registration District No. 37

State File No. 123942

Hospital

Primary Registration District No. 1085 Local Registrar's No. 1

FULL NAME OF CHILD

Clay

(Certificate of no value without full name of child)

Sex of Child

female

Twin
Triplet
or other?

✓ and

(Number
in order
of birth)

Legiti-
mate?

yes

Date of
birth

July 4

1924

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

none

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FULL
NAME

FATHER

I. Clay

RESIDENCE

Twin Falls, Idaho

COLOR

white

AGE AT LAST
BIRTHDAY

38
(Years)

BIRTHPLACE

England

OCCUPATION

Agt American Express

FULL
MAIDEN
NAME

MOTHER

Lulu Sneed

RESIDENCE

Twin Falls Idaho

COLOR

white

AGE AT LAST
BIRTHDAY

38
(Years)

BIRTHPLACE

Mo

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive born July 4 at 41 P M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature)

John G. Coughlin
Physician
(Physician or midwife)

Address

Twin Falls, Idaho

Filed Aug. 1 1924

Registrar.

Registrar.

DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS
 STATE OF NEW YORK
 COUNTY OF ...
 CITY OF ...
 No. ...
 Primary Registration District No. ...
 Hospital ...
 FULL NAME OF CHILD ...
 Sex of Child ...
 Date of Birth ...
 (Month) (Day) (Year)
 (Certificate of no value without full name of child)
 Number of child of this mother, including previous birth ...
 Number of child of this mother, including previous birth ...
 If but non-identical solution was made in event?
 FULL NAME FATHER ...
 FULL NAME MOTHER ...
 RESIDENCE ...
 AGE AT LAST BIRTHDAY (Years) ...
 COLOR ...
 BIRTHPLACE ...
 OCCUPATION ...
 CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who was ...
 (Signature) ...
 (Address of midwife) ...
 Address ...
 Filed ...
 192...

When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathed nor shows other evidence of life after birth. Also return must be made from a medical report on the date above stated.

DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS
 STATE OF NEW YORK
 COUNTY OF ...
 CITY OF ...
 No. ...
 Primary Registration District No. ...
 Hospital ...
 FULL NAME OF CHILD ...
 Sex of Child ...
 Date of Birth ...
 (Month) (Day) (Year)
 (Certificate of no value without full name of child)
 Number of child of this mother, including previous birth ...
 Number of child of this mother, including previous birth ...
 If but non-identical solution was made in event?
 FULL NAME FATHER ...
 FULL NAME MOTHER ...
 RESIDENCE ...
 AGE AT LAST BIRTHDAY (Years) ...
 COLOR ...
 BIRTHPLACE ...
 OCCUPATION ...
 CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who was ...
 (Signature) ...
 (Address of midwife) ...
 Address ...
 Filed ...
 192...

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Twin FallsRegistration District No. 37City of Idaho FallsPrimary Registration District No. 1085(No. 167 Washington North St.)State File No. 46532Local Registrar's No. 1211

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Clay

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

FemaleWhiteInfant
(Write the word)

6. DATE OF BIRTH

July 4 1924
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many
hrs. or min.?0 Yrs. 0 Mos. 0 ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Irwin Clay

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mae Inead

13. BIRTHPLACE OF MOTHER

(State or Country)

Mesquite

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Irwin Clay
(Address) Twin Falls Idaho

15.

Irwin Clay
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 4 1924
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 1924 to 1924that I last saw him alive on 1924, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Stillborn (Embar pregnancy)(Duration) 0 yrs. 0 mos. 0 ds.

Contributory (Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed)

Thos. Staudt M. D.(Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death 0 yrs. 0 mos. 0 days. State 0 yrs. 0 mos. 0 ds.

Where was disease contracted

If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls IdahoJuly 5 1924

20. UNDERTAKER

ADDRESS

J. E. DeWittTwin Falls

See instructions on back of certificate.

Exact statement of

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

818 104 003-919
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Bannock
City of Pocatello
No. 141504 District No. 28 File No. 124086
Hospital _____ Primary Registration District No. 2161 Registered No. 6526

FULL NAME OF CHILD William Faybalf
(Certificate of no value without full name of child.)

Sex of Child Male Twin Triplet or other? 1 and Number in order of birth _____ Legitimate? yes Date of birth July 4 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bacteriocidal solution was used in eyes? Slit's Balm

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Robert Faybalf
RESIDENCE 141504 1st
COLOR white AGE AT LAST BIRTHDAY 33 (Years)
BIRTHPLACE Togay, Utah
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Ida Rainey
RESIDENCE 141504 1st
COLOR white AGE AT LAST BIRTHDAY 32 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was slit's at 4309 M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 19____

Registrar.

(Signature) W. Lynn
(Physician or midwife)
Address Pocatello, Idaho
Filed 8/1 1924 W. Young
Registrar.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **46606**
Registered No. **4381**

1. PLACE OF DEATH **RECEIVED**
County of **Bannock** Registration District No. **28**
City of **Pocatello** Registration District No. **2141** St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Hayball

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH

July 4 1924
(Month) (Day) (Year)

7. AGE

still born IF LESS than 1 day
Yrs. Mos. ds. how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country) **141 So 4th city**

10. NAME OF FATHER

Robert Hayball

11. BIRTHPLACE OF FATHER

(State or Country) **Logan Utah**

12. MAIDEN NAME OF MOTHER

Sda Rainey

13. BIRTHPLACE OF MOTHER

(State or Country) **Idaho**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

H. Lynn Pocatello

15.

Filed **7/4 1924**

J. Lynn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

7 - 4 - 24
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **July 4 1924** to **July 4 1924** that I last saw him **live** on **July 4 1924** and that death occurred on the date stated above, at **3:00 M.** The CAUSE OF DEATH* **was** as follows:
permanence birth

(Duration) Yrs. mos. ds.

Contributory (Secondary) **Still Born**

(Duration) yrs. mos. ds.

(Signed) **J. H. Lynn M. D.**

7/4 1924 (Address) **Pocatello, Ida.**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

MT View

DATE OF BURIAL

7/4 1924

20. UNDERTAKER

Robert Hayball

ADDRESS

Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary); may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

S S

FILE # 124108

YEAR 1924

IDAHO STILLBIRTH CERTIFICATE

X ☒ VOID STILLBIRTH RECORD
DUP OF 1924-120745

25 3/25 003866

PLACE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTHS
124116County of Bannock,City of DowneyNo. R.D. St.Registration District No. 88

File No.

Hospital

Primary Registration District No. 2160 Registered No. 86

FULL NAME OF CHILD

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>Yes</u>	Date of Birth <u>July - 25 - 1924</u> (Month) (Day) (Year)
--------------------------	---	-----	---	-----------------------------	--

FULL NAME <u>P. W. Beckman</u>	FATHER
RESIDENCE <u>Downey, Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>29</u> (Years)
BIRTHPLACE <u>Downey, Idaho</u>	
OCCUPATION <u>farmer</u>	

FULL MAIDEN NAME <u>Daisy</u>	MOTHER
RESIDENCE <u>Downey, Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>Ogden, Utah</u>	
OCCUPATION <u>housewife</u>	

Number of child of this mother, including present birth <u>5th</u>	Number of children of this mother now living, including present birth <u>8</u>
---	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive or stillborn, at 10:00 A. M. on the date above stated.

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

(Physician or midwife)

Given names added from a supplemental report.

19.

Address

Filed

Registrar

Registrar

UNITED STATES DEPARTMENT OF JUSTICE
BUREAU OF PRISONS
WASHINGTON, D. C.

2

Primary Registration District No. 8
City of New York

NAME OF PRISON

and in case of death
Number of days in custody

MOTHER

NAME
BIRTH DATE

RESIDENCE

COLOR

AGE AT LAST
(MONTHS)

BIRTH DATE

OCCUPATION

CERTIFICATE OR ATTENDING PHYSICIAN OR MIDWIFE

(Signature)

TO BE FILLED IN BY THE PRISONER OR HIS ATTORNEY

DATE OF BIRTH

Address

Signature

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH 124145

County of *Bennah*City of *St. Maries*No. *75522005-76* St. Registration District No. *32* State File No.Hospital *St. Maries* Primary Registration District No. *2049* Local Registrar's No. *74*FULL NAME OF CHILD *Infant Leeson, Gertrude*

(Certificate of no value without full name of child)

Sex of Child <i>Female</i>	Twin Triplet or other? <i>—</i>	and { Number in order of birth <i>—</i> }	Legitimate? <i>yes</i>	Date of birth <i>7-12-1924</i>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes? *None*Number of child of this mother, including present birth *1* Number of child of this mother now living, including present birth *1*

FATHER		MOTHER	
FULL NAME <i>Albert E. Leeson</i>		FULL MAIDEN NAME <i>Gertrude Law</i>	
RESIDENCE <i>St. Maries, Ida.</i>		RESIDENCE <i>St. Maries, Idaho</i>	
COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>25</i> (Years)	COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>19</i> (Years)
BIRTHPLACE <i>Vermont</i>		BIRTHPLACE <i>St. Maries, Idaho</i>	
OCCUPATION <i>Truck driver</i>		OCCUPATION <i>Housewife</i>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { *Born alive* / *Stillborn* } at *2 40 P. M.* on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) *Delamare*

(Physician or midwife)

Address *St. Maries, Idaho*Filed *Aug 9* 1924 *Deunager*

Registrar.

Registrar.

BIRTH STATED

CHERRYLAND OF BIRTH 120148

St. Registration Number 120148

Primarily Registered Number 120148

(Certificate of No Validity and Reason of Cancellation)

Number of children of this mother and father including present birth
 (Date of Birth) (Date of Birth) (Date of Birth) (Date of Birth)

Number of children of this mother and father including present birth

MOTHER
 FULL NAME
 MAIDEN NAME

RESIDENCE

AGE AT LAST BIRTHDAY

COLOR

ETHNIC RACE

OCCUPATION

AGE AT LAST BIRTHDAY (Last)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

Signature and Date of Birth of this child, who was

(Signature)

Signature of Registrar

Address

Filed

Registration

Form No. 10-1-1

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Benedict
City of Romana

Registration District No. 32
Primary Registration District No. 2049
(No. Romana Hosp St.)

State File No. 46623
Local Registrar's No. 42

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gertrude Leeson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

July 12 1924
(Month) (Day) (Year)

7. AGE

Stillborn

IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

none

9. BIRTHPLACE

(State or Country) St. Maries, Ida.

10. NAME OF FATHER

Al E. Leeson

11. BIRTHPLACE OF FATHER

(State or Country) Mont Vernon New York

12. MAIDEN NAME OF MOTHER

Gertrude Laws

13. BIRTHPLACE OF MOTHER

(State or Country) St. Maries, Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mable Laws
(Address) St. Maries, Ida.

15. Filed July 12 1924 Stillman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 12 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
..... 19..... to 19.....
that I last saw h..... alive on..... 19.....
and that death occurred on the date stated above, at..... M.
The CAUSE OF DEATH* was as follows:

Stillborn at eight months
cause placental infarction
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) Delaware M. D.
7/5/24 (Address) St. Maries

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn

DATE OF BURIAL

7-15 1923

20. UNDERTAKER

Mitchell & Menager St. Maries, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Blaine RECEIVED
City of Carey SEP 3 1924
No. 713 128-007 409 BUREAU OF VITAL STATISTICS District No. 57 State File No. _____
Hospital _____ Primary Registration District No. 2075 Local Registrar's No. 31
FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ and { Number in order of birth _____ } Legitimacy Yes Date of birth 3-28 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth _____

Number of child of this mother now living, including present birth _____

FATHER
FULL NAME Thos. L. Patterson
RESIDENCE Carey
COLOR W hite. AGE AT LAST BIRTHDAY 42 (Years)
BIRTHPLACE Utah
OCCUPATION Mechanic

MOTHER
FULL MAIDEN NAME Bertha M. Markham
RESIDENCE Carey
COLOR W hite AGE AT LAST BIRTHDAY 40 (Years)
BIRTHPLACE Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 11:30 a. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Booster E. Snyder
Physician
(Physician or midwife)

Address

Filed

Carey Ida
8-75 1924 Robert H. Wright
Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

54185

1. Name of child: _____
2. Sex: _____
3. Date of birth: _____
4. Place of birth: _____
5. Hospital or institution: _____

6. Name of mother: _____
7. Name of father: _____
8. Date of marriage: _____
9. Place of marriage: _____
10. Name of mother at birth: _____
11. Name of father at birth: _____

MOTHER		FATHER	
NAME	RESIDENCE	NAME	RESIDENCE
NAME	RESIDENCE	NAME	RESIDENCE
AGE AT LAST BIRTHDAY	COLOR	AGE AT LAST BIRTHDAY	COLOR
BIRTHPLACE	OCCUPATION	BIRTHPLACE	OCCUPATION

12. Name of attending physician or midwife: _____
13. Signature of attending physician or midwife: _____
14. Date of registration: _____
15. Address: _____

NOTED BY _____
DATE OF REGISTRATION _____
NAME OF REGISTRAR _____
ADDRESS OF REGISTRAR _____

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

Blaine SLP 8
Carey

City of

Registration District No. 57

Primary Registration District No. 2025

(Name)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

46644

Registered No.

17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

3

28

1924

(Month)

(Day)

(Year)

7. AGE

Stillborn

Yrs. Mos. da.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Gus. S. Patterson

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Bertha M. Markham

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Gus. S. Patterson
Carey Idaho

(Address)

15.

Filed

8-25

1924

P. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Don't Know

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Stillborn

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

Don't Know

(Duration)

yrs.

mos.

ds.

(Signed)

Houston C. Snyder M. D.

19

(Address)

Carey Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Carey Idaho

DATE OF BURIAL

3-29-24

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

766124 007-285
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

124195

County of Blaine

City of Bellvue

No. _____ St. _____

Registration District No. 57

File No. 124195

Hospital _____

Primary Registration District No. 2022

Registered No. 40

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of
Child

Male

Twin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

Yes

Date of
birth

7 24

1924

(Month)

(Day)

(Year)

What bacteriocidal solution was used in eyes? no

Number of child of this mother, including present birth 1

Number of child of this mother now living, including present birth 0

FULL
NAME

FATHER

John A. Powers

FULL
MAIDEN
NAME

MOTHER

Rachel Sherbine

RESIDENCE

Bellvue, Idaho

RESIDENCE

Bellvue, Idaho

COLOR

White

AGE AT LAST

BIRTHDAY 33

(Years)

COLOR

White

AGE AT LAST

BIRTHDAY 16

(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Hanover, Idaho

OCCUPATION

Farmer

OCCUPATION

House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.

Phillips

at 4 2 M.
(Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

(Physician or midwife)

Give names added from a supplemental report.

_____, 19____

Address

Hanley, Idaho

Filed

8-5 1924

Robert H. Wright

Registrar.

Registrar.

5/1

23

2
12

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Blaine
City of Belevue

Registration District No. 57
Primary Registration District No. 2022
(No. St.)

File No. 10048
Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Powers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH 7 24 1924
(Month) (Day) (Year)

7. AGE steele Born IF LESS than 1 day how many 0 hrs. or min.?
Yrs. Mos. ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work L
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Belevue, Idaho
(State or Country)

10. NAME OF FATHER John H. Powers

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Rachel Sherbine

13. BIRTHPLACE OF MOTHER Stanton, Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John H. Powers
(Address) Belevue, Idaho

15. Filed 8-15 1924 O. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 24 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/24 1924 to 7/24 1924 that I last saw him alive on 7/24 1924 and that death occurred on the date stated above, at 4 a.m. The CAUSE OF DEATH* was as follows:
Premature birth, 7 mo

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) [Signature] M. D.
7/24 1924 (Address) Harley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Belevue, Ida DATE OF BURIAL 7-24-1924

20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of BonnerCity of Land PointNo. 504 Eliza St.Hospital 381-103 889-314Registration District No. 78 State File No. 124255Primary Registration District No. 2155 Local Registrar's No. Hoyd ChamberlainFULL NAME OF CHILD Hoyd Chamberlain

(Certificate of no value without full name of child.)

Sex of Child <u>Im</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>Aug 3</u> 192 <u>4</u> (Month) (Day) (Year)
------------------------	-----------------------------------	-----------------------------------	------------------------	---

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth <u>4</u>	Number of child of this mother now living, including present birth <u>3</u>
FATHER FULL NAME <u>Harry Chamberlain</u>	MOTHER FULL MAIDEN NAME <u>Maud Chamberlain Cady</u>
RESIDENCE <u>Land Point</u>	RESIDENCE <u>Land Point</u>
COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>38</u> (Years)	COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>34</u> (Years)
BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Idaho</u>
OCCUPATION <u>Painter</u>	OCCUPATION <u>Bookkeeper</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at Land Point on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Viola Allen

(Physician or midwife)

Give names added from a supplemental report.

Address Land PointFiled Sept 2 1924

Registrar.

Deputy Registrar.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

THIS IS A CERTIFICATE OF BIRTH FOR THE CHILD OF THE MOTHER AND FATHER NAMED ABOVE. IT IS TO BE USED FOR THE PURPOSES OF THE STATE OF IDAHO. IT IS TO BE FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE DISTRICT IN WHICH THE CHILD WAS BORN. IT IS TO BE KEPT IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE DISTRICT IN WHICH THE CHILD WAS BORN. IT IS TO BE KEPT IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE DISTRICT IN WHICH THE CHILD WAS BORN.

FULL NAME OF CHILD

(Certificate of no name without full name of child)

Sex of Child	and of Mother	and of Father	Date of Birth (Month)	Date of Birth (Day)
--------------	---------------	---------------	-----------------------	---------------------

At birth, the child was found in the arms of the mother.

At birth, the child was found in the arms of the mother.

MOTHER'S NAME	FATHER'S NAME
---------------	---------------

COLOR	AGE AT LAST BIRTHDAY	COLOR	AGE AT LAST BIRTHDAY
BIRTHPLACE	OCCUPATION	BIRTHPLACE	OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I, _____, a duly licensed physician or midwife, attended the birth of this child, who was born on _____ at _____, Idaho.

(Signature)	(Address)
-------------	-----------

When there was no attending physician or midwife, the mother or father, or both, should make this return. A certified child is one that neither practices nor shows other evidence of life after birth.

Give proper child, name, and date of birth.

103

Filed

103

103

103

103

103

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

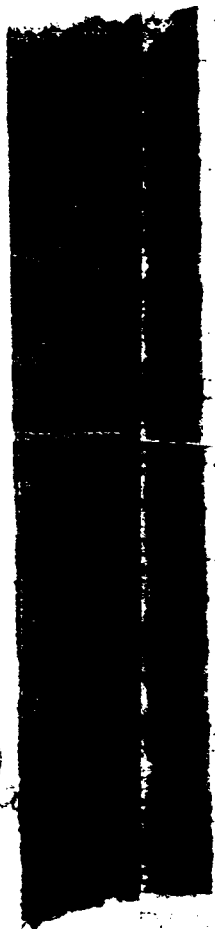
Place of Birth	(CITY <u>Sandpoint</u>	FILE NO. <u>124255</u>
	(ST. <u> </u>	DATE OF BIRTH <u>3 Aug 3</u>
	(COUNTY <u>Bonanza</u>	SEX OF CHILD <u>Male</u>
FATHER <u>Harry Chamberlain</u>		MOTHER <u>Maud Chamberlain</u> (MAIDEN NAME)

I HEREBY CERTIFY that the child herein described has been named:

Floyd Chamberlain

Mrs Harry Chamberlain
Signature of Father or Mother.

RECEIVED
JUL 10 1933



pla

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH

 County of Bonner
 City of Sandpoint

RECEIVED

District No. 78

SEP 6 1924

Registration District No. 2155

BUREAU OF VITAL

File No. 46664

Registered No. _____

 If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Chamberlain
 If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMarried
(Write the word.)

6. DATE OF BIRTH

Aug
(Month)3
(Day)1924
(Year)

7. AGE

Stillborn
Yrs. Mos. ds.
 IF LESS than 1 day
 how many hrs.
 or min. ?

8. OCCUPATION

 (a) Trade, profession or
 particular kind of work.
 (b) General nature of in-
 dustry, business or estab-
 lishment in which employ-
 ed (or employer)
Dead

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERHarry Chamberlain11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho12. MAIDEN NAME
OF MOTHERMaude Hasty Cady13. BIRTHPLACE
OF MOTHER

(State or Country)

Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Magdalen Chamberlain

(Address)

Sandpoint

15.

Filed Aug 4 1924
Viola Alder
 Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug
(Month)3
(Day)1924
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 3 1924 to Aug 3 1924that I last saw him Stillborn 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Malformation

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) R. J. Kelly M. D.Aug 2 1924 (Address) Sandpoint
 *State the Disease Causing Death; or in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Fakesin Cemetery

DATE OF BURIAL

Aug 4 1924

20. UNDERTAKER

Harry Chamberlain (father) Sandpoint

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc.). The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

469-2101942

PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-3-3-37

County of Boundary

CERTIFICATE OF BIRTH

City of Bonners FerryRegistration District No. 79File No. 124293

No. St.

Primary Registration District No. 2156

Registered No.

Hospital Bonners Ferry

FULL NAME OF CHILD

Selen Morgan

Sex of Child <u>Female</u>	Twin Triplet or other? <input checked="" type="checkbox"/> and (Number in order of birth) <input checked="" type="checkbox"/>	Legitimate? <u>yes</u>	Date of Birth <u>July 11</u> 19 <u>24</u> Month (Day) (Year)
----------------------------	---	------------------------	---

FULL NAME <u>Geo. B. Morgan</u>	FATHER
RESIDENCE <u>Meadow Creek, Ida</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>40</u> (Years)
BIRTHPLACE <u>England</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Selen Russell</u>	MOTHER
RESIDENCE <u>Meadow Creek</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)
BIRTHPLACE <u>England</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth... 0 Number of children of this mother now living, including present birth... 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn (Born alive or stillborn) at 6 P. M. on the date above stated.

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. E. Fry
Physician
(Physician or midwife)

Given names added from a supplemental report.

Address Bonners Ferry, Ida
Filed 7/12/24 1924
E. E. Fry
Registrar



0117

2

6

14

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of BoundaryCity of Bonniers Ferry

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 79Primary Registration District No. 2156

(No.)

St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. 16692

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hellen Morgan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

July11th1924

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1
day how many
hrs. or
min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Bonniers Ferry, Ida.

10. NAME OF

Father

Geo. B. Morgan

11. BIRTHPLACE

OF FATHER

(State or Country) Minnesota

12. MAIDEN NAME

OF MOTHER

Hellen Russell

13. BIRTHPLACE

OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. B. Morgan(Address) Meadow Creek, Ida.

15.

Filed

July 11th 1924S. S. Fry

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July111924

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19that I last saw him alive on 19and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Stillborn
(Suffocative - Breach presentation)

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) S. S. Fry M. D.7/11/1924 (Address) Bonniers Ferry, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonniers Ferry, Ida.July 12, 1924

20. UNDERTAKER

ADDRESS

A. M. Peterson Bonniers Ferry

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"). Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each, and the number of each, in order of birth stated.

433108-017-593
PLACE OF BIRTH

County of Clark

City of Winsper

No. _____ St.

Hospital _____

FULL NAME OF CHILD

Registration District No. 120 File No. 124378

Primary Registration District No. 2203 Registered No. _____

FULL NAME OF CHILD Oliver McCune Jr.

Sex of Child <u>Male</u>	Twin Triplet or other? <u>No</u>	and {	Number in order of birth <u>2</u>	Legiti mate? <u>Yes</u>	Date of Birth <u>July 8</u> 19 <u>24</u> (Month) (Day) (Year)
--------------------------	----------------------------------	-------	-----------------------------------	-------------------------	--

FULL NAME FATHER Oliver McCune

RESIDENCE Winsper CO

COLOR White AGE AT LAST BIRTHDAY 24 (Years)

BIRTHPLACE Kansas

OCCUPATION Mail Carrier

FULL MAIDEN NAME MOTHER Collier J. Nichols

RESIDENCE Winsper CO

COLOR White AGE AT LAST BIRTHDAY 19 (Years)

BIRTHPLACE Idaho

OCCUPATION Housewife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn, at 10:30 P.M. on the date above stated. (Design alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report.

(Signature) _____

(Physician or midwife)

Address Subsidiary

Filed July 9 1924 W. E. Jones M.D. Registrar

Registrar

876451

2.

Primary Registration District No. 1 Registered No. 1

Letigrau H

FILE NAME OF CHILD

Child
Sex of

모두가

FATHER

NAME
MADSEN
FULL

COLORED

TRAJ TA BDA
YACHTIB

АДВОКАТ

SIXTH PLACE

BIRTHPLACE

NOTARION

MMIT A9000

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

on the date above stated. I hereby certify that I attended the birth of this child who was (Name) (Date) at (Place)

*When there was no attending physician to receive them the (Ladies' Board) did it. A stillborn child is not a child and it is not a child.

tropez intramoléculaire a aussi été observé

SECRET

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WABQIA RESERVED FOR BLINDS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho SEP 22 1924

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

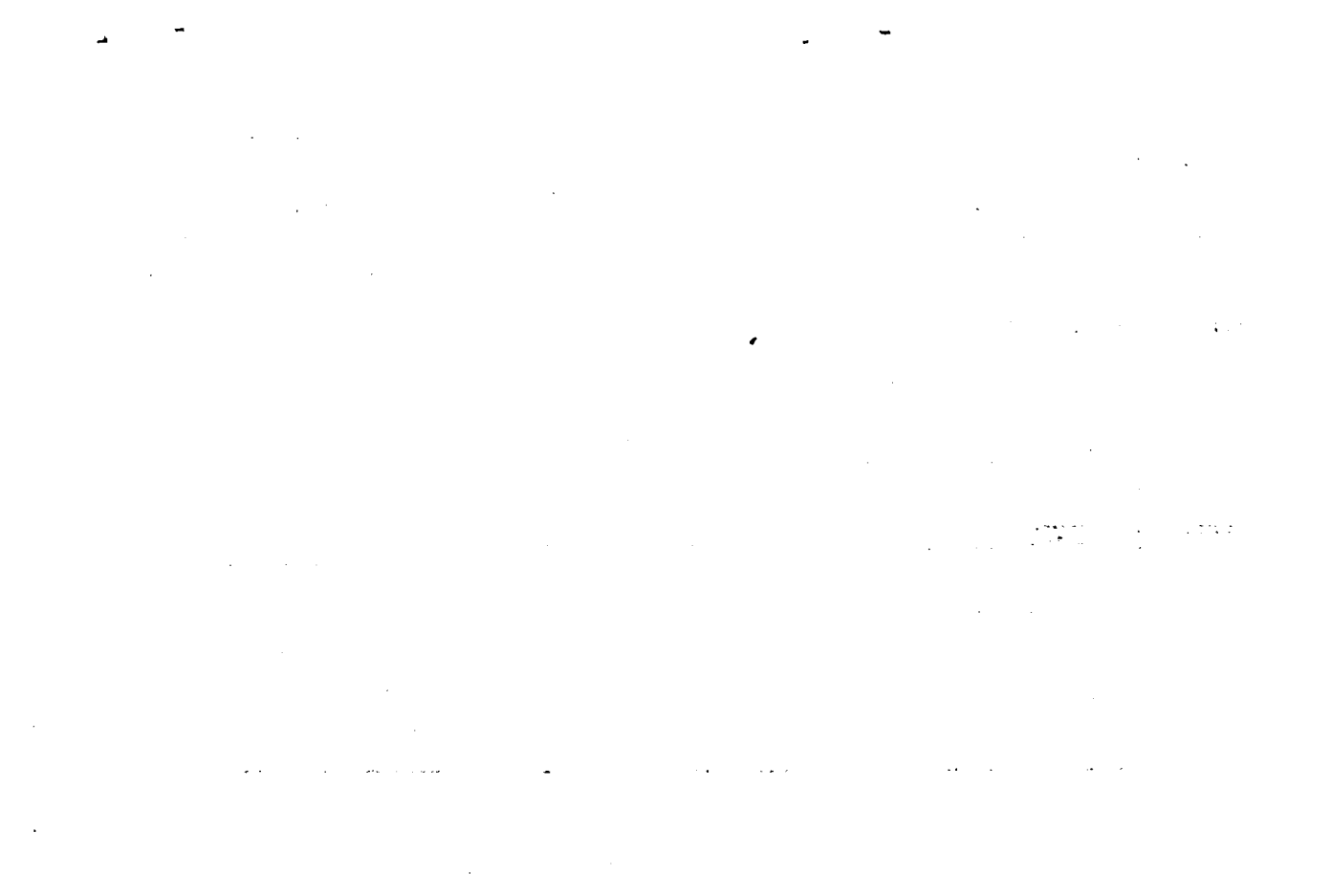
Place of Birth (CITY Winsper FILE NO. 124378
(ST. Idaho DATE OF BIRTH Sept 24
(COUNTY Clark SEX OF CHILD (Male
FATHER Oliver M. Lane MOTHER Alma Nichols
(MAIDEN NAME)

I HEREBY CERTIFY that the child herein described has been named:

Carl M. Lane

RECEIVED
SEP 22 1924

Signature of Father or Mother.



CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 125

County of

Primary Registration District No. 2203

City of

(No. St.)

If death occurs away from
usual residence, give facts
called for under special in-
formation.

Registered No.

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

July 8 1924
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) Idaho10. NAME OF
FATHEROliver M. Cune11. BIRTHPLACE
OF FATHER(State or Country) Kansas12. MAIDEN NAME
OF MOTHERChlor J. Nichols13. BIRTHPLACE
OF MOTHER(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oliver M. Cune(Address) Windsor Idaho

15.

Filed July 9 1924 BE Jones MD
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 8 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to19.....

that I last saw him alive on19.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows: no cause knownStill born - born dead
for several days
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) BE Jones M. D.7/9 1924 (Address) Idaho*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of FremontCity of TetonNo. 462-126 022-318 St.

Registration District No.

State File No.

124488

Hospital

Primary Registration District No.

Local Registrar's No.

266

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

male

Twin
Triplet
or other? noand { Number
in order
of birth no
(To be answered only in event of plural births)Legiti-
mate? yesDate of
birth8-26-24
(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FULL
NAME

FATHER

Frank Meseldine

RESIDENCE

Teton

COLOR

White

AGE AT LAST
BIRTHDAY 42
(Years)

BIRTHPLACE

England

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Grace Lay

RESIDENCE

Teton

COLOR

white

AGE AT LAST
BIRTHDAY 42
(Years)

BIRTHPLACE

England

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive Stillborn at 6:30 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

W. K. Kutterland

(Physician or midwife)

Address

Plexburg, Ida.

Filed

1924

Wm. Hansen

Registrar.

Registrar.

THIS IS A CERTIFICATE OF BIRTH AND DEATH, and is to be used in the same manner as a birth and death certificate. It is to be filled out by the attending physician or midwife, and is to be filed in the office of the Registrar of Births and Deaths.

(The names added from a supplemental report of the attending physician or midwife, should make this return. A child is one that neither parent nor mother or father has ever seen or heard of since birth.)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was born at _____ at _____

Physician or midwife

Registrar

Filed

192

BIRTHPLACE

COLOR

AGE AT LAST BIRTHDAY

COLOR

AGE AT LAST BIRTHDAY

RESIDENCE

RESIDENCE

NAME

FATHER

NAME

MOTHER

Number of child of this mother, including present birth

Number of child of this mother, including present birth

What bacteriological solution was used in eyes?

Sex of Child

Twin

and { of birth

Weight

Date of birth

Full name of child, no name without full name of child

Home

Place of birth, District No.

Local Registrar's No.

City of

County

State File No. 124488

2

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

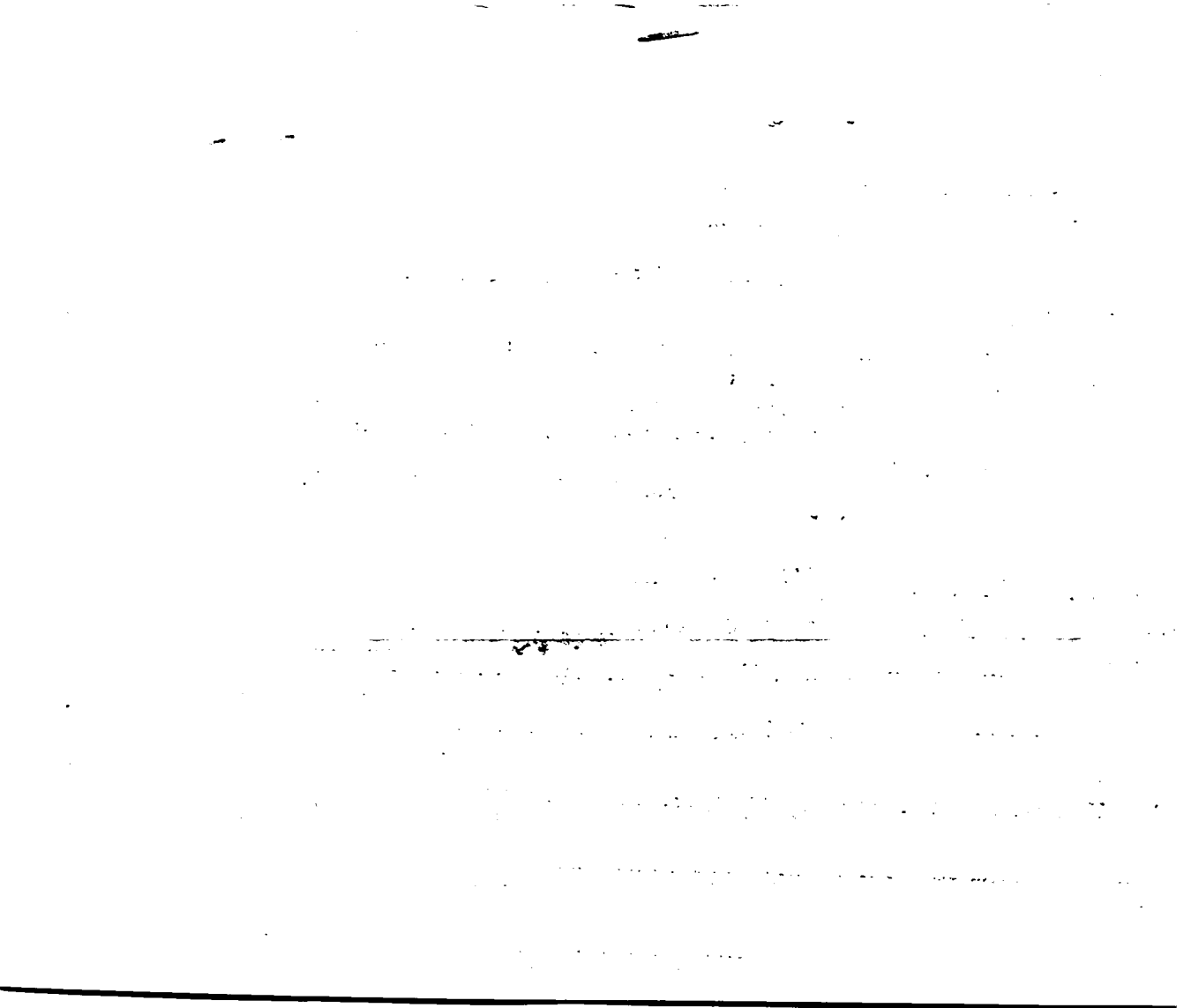
BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY Teton City FILE NO. 124488
(ST. _____ DATE OF BIRTH _____
(COUNTY Fremont SEX OF CHILD Male
FATHER Frank Marshalline MOTHER Grace F. Lay
(MAIDEN NAME)

I HEREBY CERTIFY that the child herein described has been named:

An baby was born ^{dead} Premature, there f
F. Marshalline
Signature of Father or Mother.



MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Fremont

Registration District No. 99

City of Teton

Primary Registration District No. 2177

If death occurs away from usual residence, give facts called for under special information.

(No. 1 St.)

State File No. 47376

Local Registrar's No. 87

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Stillborn
Infant Misseldine

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

male

white

Infant
(write the word)

6. DATE OF BIRTH

Stillborn

Aug
(Month)

26
(Day)

1924
(Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Teton, Ida

10. NAME OF
Father

Frank Misseldine

11. BIRTHPLACE
OF FATHER

(State or Country) England

12. MAIDEN NAME
OF MOTHER

Grace Lay

13. BIRTHPLACE
OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Misseldine

(Address)

Teton, Idaho

15.

Filed

Aug 26

1924

Wm. Hansen

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Still born

8
(Month)

26
(Day)

1924
(Year)

17. I HEREBY CERTIFY, That I attended deceased from
19. to 19.

that I last saw h. alive on 19.
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. H. Lutherslager, M. D.

9/21/1924

(Address) Peyburg, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Teton

DATE OF BURIAL

8/26 1924

20. UNDERTAKER

None

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

24970206 3/3
PLACE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTHS
124526County of JeffersonCity of RigbyRegistration District No. 98

File No. _____

No. _____ St. _____

Primary Registration District No. 2176Registered No. 356

Hospital _____

FULL NAME OF CHILD DeedSex of
ChildMaleTwin
Triplet
or other?

and

Number
in order
of birthLegiti
mate?Date of
BirthJuly 2 1924

(Month) (Day) (Year)

FULL
NAME

FATHER

Joseph A. SmithFULL
MAIDEN
NAME

MOTHER

Ida Marie Call

RESIDENCE

Rigby Idaho

RESIDENCE

Rigby Idaho

COLOR

whiteAGE AT LAST
BIRTHDAY44
(Years)

COLOR

whiteAGE AT LAST
BIRTHDAY39
(Years)

BIRTHPLACE

 Ogden Utah

BIRTHPLACE

Willard Utah

OCCUPATION

Farmer

OCCUPATION

HousewifeNumber of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn, at 2:00 P. M.
on the date above stated. (Born alive or stillborn){ When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth. }

(Signature)

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Filed

19

Registrar

Registrar

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY Regley FILE NO. 124526
(ST. DATE OF BIRTH 2 July
(COUNTY Jefferson SEX OF CHILD Male
FATHER Joseph Smith MOTHER Marie Smith
(MAIDEN NAME)

I HEREBY CERTIFY that the child herein described ~~has been named:~~

it was dead when born

Marie Marie J. H. Smith
Signature of Father or Mother.

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

1961

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of JeffersonCity of Highway

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98Primary Registration District No. 2176

(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 46776Registered No. 69

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME IDA M. CALL

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Infant

(Write the word.)

6. DATE OF BIRTH

7 - 2 1924
(Month) (Day) (Year)

7. AGE

..... Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Joseph H Smith

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Ida M. Call

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph H Smith(Address) Highway

15.

Filed 8/10 1924 Registries
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

7 - 2 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Stillborn

..... (Duration) Yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) C. W. Chene M. D.7-3 1924 (Address) Ida Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Highway

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

244 229
-028 185-

STATE OF IDAHO

S

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

County of *Kootenai*City of *Coeur d'Alene*No. *315 W Garden*

St.

Registration District No.

30

State File No.

124589

Hospital *Coeur d'Alene*Primary Registration District No. *1051*Local Registrar's No. *1083*FULL NAME OF CHILD *Mercedes Sumner*

(Certificate of no value without full name of child)

Sex of Child

*Female*Twin
Triplet
or other?

}

and {

Number
in order
of birth*2nd*Legiti-
mate?*yes*Date of
birth.*Aug 29**1924*

(Month) (Day) (Year)

What bactericidal solution was used in eyes? *none*

Number of child of this mother, including present birth

3

Number of child of this mother now living, including present birth

*1*FULL
NAME

FATHER

Geo W Sumners

RESIDENCE

*Post Falls**41*

COLOR

AGE AT LAST

BIRTHDAY

(Years)

BIRTHPLACE

Arkansas

OCCUPATION

*Teacher*FULL
MAIDEN
NAME

MOTHER

Joie Marie Sherer

RESIDENCE

Post Falls

COLOR

White

AGE AT LAST

BIRTHDAY

(Years)

BIRTHPLACE

So Dakota

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was *Born alive* { Stillborn } at *2 P. M.* on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

W. H. Koeder
Physician

(Physician or midwife)

Address

Coeur d'Alene Idaho

Filed

Sept 5

1924

J. D. Drena

Registrar.

Registrar.

each and the number of each, in U.S.A. 10-1-10

124549-124549

Register

192

I hereby certify that I attended the birth of this child, who was born on the 12th day of May, 1924, at the residence of the mother, who was a resident of the city of New York, and that the child was born alive and was a legitimate child of the mother and father named herein.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

OCCUPATION _____

BIRTHPLACE _____

AGE AT LAST BIRTHDAY _____

RESIDENCE _____

NAME _____

DATE OF BIRTH _____

LOCAL RESIDENCE _____

PRIVILEGE REGISTERED _____

STATE OF NEW YORK

124549-124549

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 2-19, 1924

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH Post Office
County of Boone Registration District No. 30
City of Boone Registration District No. 1051
(No. Cal & Hosp St.)
If death occurs away from usual residence, give facts called for under special information.

State File No. 46791
Local Registrar's No. 1427

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Summers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH Aug 27 1924
(Month) (Day) (Year)

7. AGE — Yrs. — Mos. — ds. — min.?
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF Father G. M. Summers

11. BIRTHPLACE OF FATHER (State or Country) Ark.

12. MAIDEN NAME OF MOTHER Josephine Summers

13. BIRTHPLACE OF MOTHER (State or Country) N. York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. M. Summers
(Address) Post Office, Ida.

15. Filled Sept-5- 1924 D. D. Drema
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8/29 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19,
that I last saw him alive on 8/29 1924
and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Removal from placenta stillborn
(Duration) — yrs. — mos. — ds.

Contributory (Secondary) —
(Duration) — yrs. — mos. — ds.

(Signed) W. K. Kaedeen M. D.
8/29/24 (Address) Concord Ave

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place In the of death — yrs. — mos. — days. State — yrs. — mos. — ds.
Where was disease contracted
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Local Cemetery DATE OF BURIAL Aug 30 1924

20. UNDERTAKER — ADDRESS —

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 20 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

212-010-029-238
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Latah

City of Troy

No. RD St.

RECEIVED
AUG 16 1924
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 61

File No. 124025

Hospital

Primary Registration District No. 2141

Registered No. 83

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin <u>no</u> Triplet <u>no</u> or other? <u>no</u> (To be answered only in event of plural births)	and	Number in order of birth	Legitimate? <u>yes</u>	Date of birth. <u>July 10</u> 192 <u>4</u> (Month) (Day) (Year)
----------------------------	---	-----	--------------------------	------------------------	--

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth... 4 Number of child of this mother now living, including present birth... 3

FATHER
FULL NAME D. J. Kasper
RESIDENCE Troy, Idaho RD
COLOR White AGE AT LAST BIRTHDAY 34 (Years)
BIRTHPLACE Wisconsin (Husung)
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Educa Schaymann
RESIDENCE Troy, Idaho
COLOR White AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Wisconsin (Leoman)
OCCUPATION Husung

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

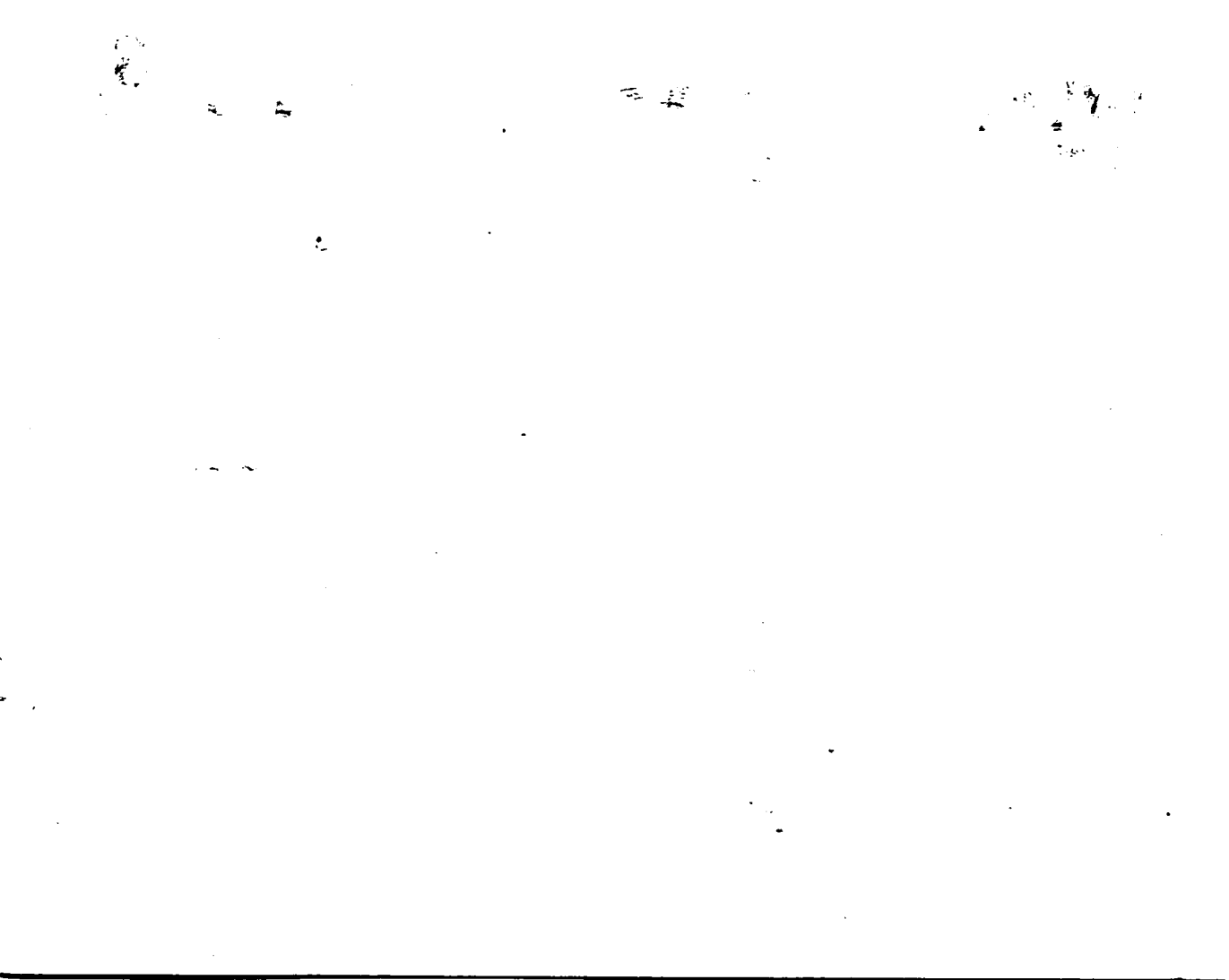
I hereby certify that I attended the birth of this child, who was... stillborn at... 11:30 A. M.
on the date above stated. (born alive or stillborn)

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Chas. L. Gutman
Physician
(Physician or midwife)

Give names added from a supplemental report.

Address Moscow, Idaho
Filed July 24, 1924 W. H. Caruthers
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

46795

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 101

County of Butte

Primary Registration District No. 2141

File No.

City of Tray

(No.)

St.)

Registered No. 34

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Kasper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

undetermined

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

July 10th 1924
(Month) (Day) (Year)

7. AGE

..... yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Tray Idaho

10. NAME OF FATHER

A. J. Kasper

11. BIRTHPLACE OF FATHER

(State or Country)

Johnsburg, Wisconsin

12. MAIDEN NAME OF MOTHER

Edna Schumann

13. BIRTHPLACE OF MOTHER

(State or Country)

Freeman, Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. J. Kasper

(Address)

Tray, Idaho

15.

Filed

July 24 1924 M. H. Barthers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 10th 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191... to July 10 1924

that I last saw him alive on 191...

and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Unknown
(Premature birth 4 1/2 months)

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. L. Gutman M. D.

7/10 1924 (Address) Moscov Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191...

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Latah AUG 14 1924
 City of Princeton
 No. 384-121-029-212 St. Registration District No. 65 State File No. 124628

Hospital _____ Primary Registration District No. 2145 Local Registrar's No. _____

FULL NAME OF CHILD Unnamed Baby

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? ☒ } and { Number in order of birth ✓ Legitimate? yes Date of birth July 21 1924
 (To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? ✓

Number of child of this mother, including present birth 8 Number of child of this mother now living, including present birth 6

FATHER
 FULL NAME Lowell Shusker
 RESIDENCE Princeton
 COLOR white AGE AT LAST BIRTHDAY 42
 (Years)
 BIRTHPLACE Missouri
 OCCUPATION Laborer

MOTHER
 FULL MAIDEN NAME Ida Baker
 RESIDENCE Princeton
 COLOR white AGE AT LAST BIRTHDAY 40
 (Years)
 BIRTHPLACE Iowa
 OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive { Stillborn } at 2 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

D. J. Thompson

(Physician or midwife)

Address

Booth

Filed

Aug 15 1924

D. J. Thompson
 Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
 N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

STATE OF IBAHO
DEPARTMENT OF SOCIAL WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 2 State File No. 63

Primary Registration District No. 2 Local Registration District No. 2

Certificate of no issue without full name of child

Sex of child ☒ Male ☐ Female
Date of birth (Month) (Day) (Year)
Place of birth (City) (County) (State)

Number of child of this mother, including present birth

MOTHER

FULL NAME

RESIDENCE

COLOR

AGE AT LAST BIRTHDAY

BIRTHPLACE

OCCUPATION

Number of child of this mother, including present birth

FATHER

FULL NAME

RESIDENCE

COLOR

AGE AT LAST BIRTHDAY

BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

(Signature)

(Physician or midwife)

Address

City

When there was no attending physician or midwife present, the father, mother, or other person present at the birth of the child, who was present at the birth of the child, shall sign this certificate.

1921

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

753 #0-032-243
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Lincoln,
City of Richfield,
No. _____ St. _____
Hospital _____
Registration District No. 16 File No. _____
Primary Registration District No. 2016 Registered No. 245
FULL NAME OF CHILD Unnamed
(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twins Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>7-10-24</u> 192 <u>4</u> (Month) (Day) (Year)
--------------------------	--	-----	--------------------------------	--------------------------------	--

What bacteriocidal solution was used in eyes? No.

Number of child of this mother, including present birth 8 Number of child of this mother now living, including present birth 6

FATHER	MOTHER
FULL NAME <u>Samuel Peterson</u>	FULL MAIDEN NAME <u>Ruth Butler</u>
RESIDENCE <u>Richfield, Idaho</u>	RESIDENCE <u>Richfield, Idaho</u>
COLOR <u>White</u>	COLOR <u>White</u>
AGE AT LAST BIRTHDAY <u>38</u> (Years)	AGE AT LAST BIRTHDAY <u>36</u> (Years)
BIRTHPLACE <u>Denmark</u>	BIRTHPLACE <u>Colorado</u>
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn, at 12-30 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Hubert C Drane MD

Physician.
(Physician or midwife)

Give names added from a supplemental report.
_____, 19_____

Registrar.

Address Shoshone, Idaho
Filed July 13 1924 J. H. Tinner
Registrar.

2

ATTHAG



EDM

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of minadottaCity of PaulNo. 819-108 034 212Registration District No. 19State File No. 124692

Hospital

Primary Registration District No. 2012Local Registrar's No. 96

FULL NAME OF CHILD

Wilfred Harris

(Certificate of no value without full name of child)

Sex of
ChildmaleTwin
Triplet
or other?

}

and {

Number
in order
of birth

}

(To be answered only in event of plural births)

Legiti-
mate?yesDate of
birth10 - 8 -1924

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Argyrol 10.70

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FULL
NAME

FATHER

James F. Harris

RESIDENCE

Paul, Idaho

COLOR

WAGE AT LAST
BIRTHDAY25
(Years)

BIRTHPLACE

Salt Lake City, Utah

OCCUPATION

FarmerFULL
MAIDEN
NAME

MOTHER

Inez May Babbitt

RESIDENCE

Paul, Idaho

COLOR

WAGE AT LAST
BIRTHDAY24
(Years)

BIRTHPLACE

Elba, Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was, { Born alive { at 6 A.M.
on the date above stated. { Stillborn {*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

(Signature)

G. H. Cooper

(Physician or midwife)

Address

Paul, Idaho

Filed

Aug. 11 1924

Registrar.

Registrar.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Minidoka 1904
 City of Minidoka BUREAU OF VITAL STATISTICS
 No. 918 209 034 689 St. Registration District No. 19 File No. 124693
 Hospital _____ Primary Registration District No. 2015 Registered No. 97
 FULL NAME OF CHILD Stillborn
 (Certificate of no value without full name of child.)

Sex of Child Female Twin Triplet or other? and Number in order of birth 1 Legitimate? yes Date of birth Aug. 9 1924
 (To be answered only in event of plural births) (Month) (Day) (Year)

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth... 3 Number of child of this mother now living, including present birth... 2

FATHER		MOTHER	
FULL NAME	<u>Wm. E. Hayes</u>	FULL MAIDEN NAME	<u>Silvia Elizabeth White</u>
RESIDENCE	<u>Minidoka</u>	RESIDENCE	<u>Minidoka</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>30</u> (Years)	AGE AT LAST BIRTHDAY	<u>30</u> (Years)
BIRTHPLACE	<u>Iowa</u>	BIRTHPLACE	<u>England</u>
OCCUPATION	<u>Boilermaker</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3:10 a. M.
 on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. D. Ehrens
M. D.
 (Physician or midwife)

Give names added from a supplemental report.

_____, 19____

Registrar.

Address _____
 Filed Aug. 9 1924 E. D. Ehrens
 Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
 N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
 and the number of each, in order of birth stated.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF-DEATH
County of Mundaka
City of Mundaka

Registration District No. 19
Primary Registration District No. 215
(No. 2 St.)

State File No. 46832
Local Registrar's No. 20

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stillborn Hayes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH August 1 1924
(Month) (Day) (Year)

7. AGE 0 Yrs. 0 Mos. 0 ds. IF LESS than 1 day how many 0 hrs. or 0 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Stillborn
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF Father Wm. E. Hayes

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER William Eliza White

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Father

(Address)

15. Filed Aug. 11 1924 E. H. Moore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 9 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19, that I last saw h..... alive on 19, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Stillborn. Died about 10 mo before birth and six weeks before period of gestation complete.
(Duration) 0 yrs. 0 mos. 0 ds.
Contributory Cause not known but
(Secondary) second child mentally & physically defective
(Signed) E. H. Moore M. D.
8-11-1924 (Address) Perfert. Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury, and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 19

20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

815-206-035-493
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

124718

County of Nezperce
City of Lewiston
No. Miller St. Registration District No. 96 File No. 124718
Hospital Primary Registration District No. 1009 Registered No. 1009
FULL NAME OF CHILD Bill Born

(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin Triplet or other? <u>and</u> { Number in order of birth <u>4</u> }	Legitimate? <u>yes</u>	Date of birth <u>6</u> <u>6</u> <u>1924</u> (Month) (Day) (Year)
----------------------------	---	------------------------	---

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 2

FATHER		MOTHER	
FULL NAME	<u>Julius Hansen</u>	FULL MAIDEN NAME	<u>Ira Miller</u>
RESIDENCE	<u>Lewiston Idaho</u>	RESIDENCE	<u>Lewiston Idaho</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>48</u> (Years)	AGE AT LAST BIRTHDAY	<u>38</u> (Years)
BIRTHPLACE	<u>Idaho</u>	BIRTHPLACE	<u>Idaho</u>
OCCUPATION	<u>Carpenter</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born dead at 8:30 a.m.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

E. F. Varnum M.D.
Lewiston Idaho
(Physician or midwife)

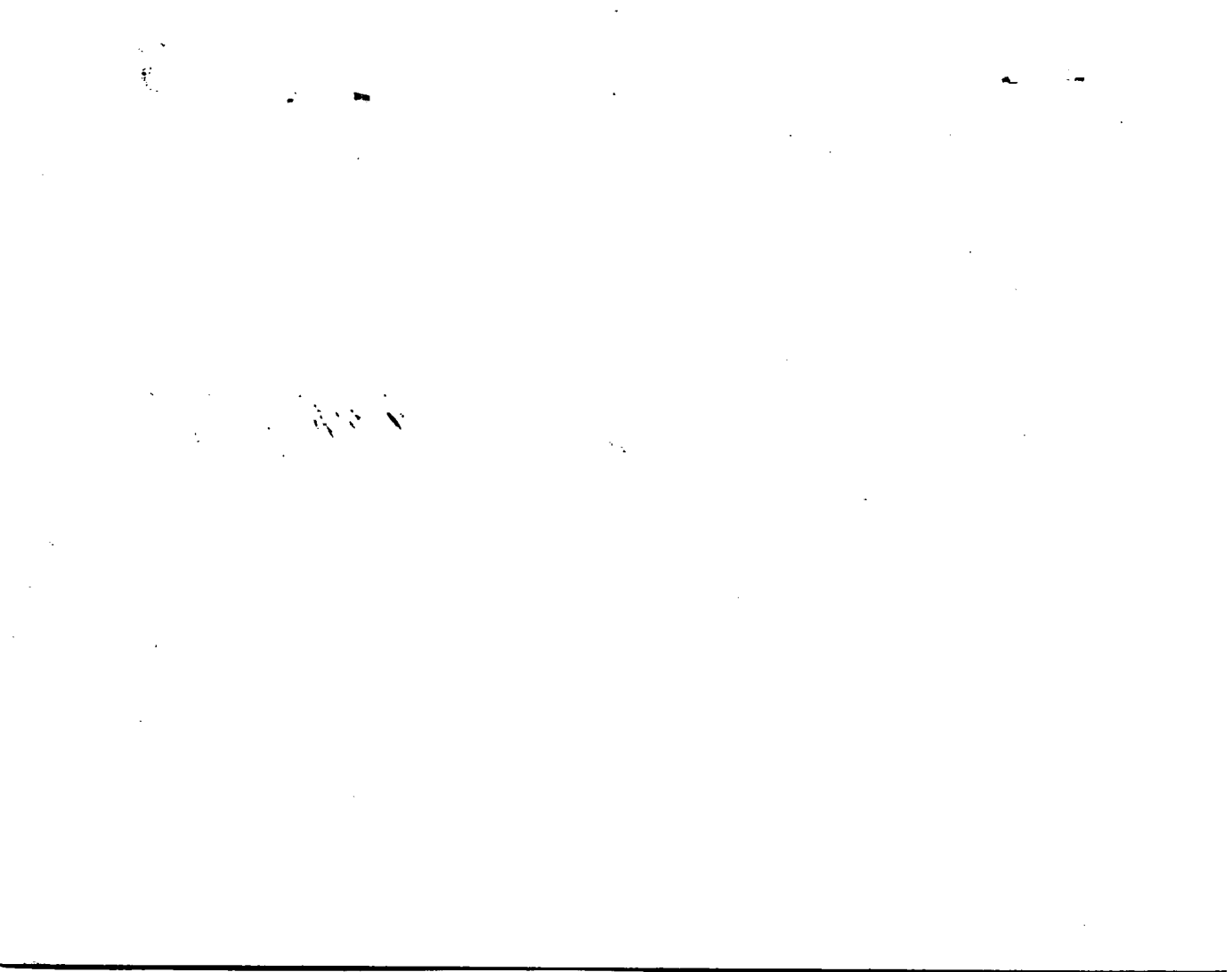
Give names added from a supplemental report.

Address

Filed Aug 15 1924 Arman E Bruce

Registrar.

Registrar.



CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Boyer*City of *Christine*Registration District No. *96*Primary Registration District No. *1009*(No. *Boyer*)

St.)

File No. *46841*Registered No. *46841*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Baby Hansen*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*4. COLOR OR RACE *White*5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)6. DATE OF BIRTH *July 5 1924*
(Month) (Day) (Year)7. AGE *Shilborn*IF LESS than 1 day
how many hrs.
or min. ?8. OCCUPATION *Infant*(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).9. BIRTHPLACE *Ida.*

(State or Country)

10. NAME OF FATHER *Julius Hansen*11. BIRTHPLACE OF FATHER *Minnesota*

(State or Country)

12. MAIDEN NAME OF MOTHER *Ira Miller*13. BIRTHPLACE OF MOTHER *Idaho*

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Julius Hansen*(Address) *Leviston, Idaho*
*633 Miller St.*15. *Aug*Filed *July 15 1924**John E. Bruce*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *July 5 1924*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
..... 19....., to 19.....
that I last saw him alive on 19.....
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Infant Born dead

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *E. F. Immers* M. D.19..... (Address) *Leviston, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Leviston, Ida*DATE OF BURIAL *7/5 1924*20. UNDERTAKER *Vassar and Co*ADDRESS *Leviston, Idaho*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

124727

County of Oneida
City of Stone
No. 893716 036 713 St. SEP 1 1924 Registration District No. 26 State File No. 2069
Hospital _____ Primary Registration District No. 2069 Local Registrar's No. 115-
FULL NAME OF CHILD Baby Hickman

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? Yes Date of birth Aug 16 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FATHER
FULL NAME Harvey Earl Hickman
RESIDENCE Stone Idaho
COLOR White AGE AT LAST BIRTHDAY 27 (Years)
BIRTHPLACE Snowville Utah
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Alta Pack
RESIDENCE Stone Idaho
COLOR White AGE AT LAST BIRTHDAY 27 (Years)
BIRTHPLACE Millard Co Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 3 30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Edward Leigh M.D.
Physician

(Physician or midwife)

Address

Snowville Utah

Filed

8/31

1924

J. M. Turner

Registrar.

Registrar.

1. State of birth of child
 2. Date of birth of child
 3. Name of child
 4. Sex of child
 5. Color of child
 6. Religion of child
 7. Occupation of child
 8. Address of child
 9. Name of mother
 10. Name of father
 11. Name of attending physician
 12. Name of midwife
 13. Name of nurse
 14. Name of doctor
 15. Name of hospital
 16. Name of clinic
 17. Name of school
 18. Name of church
 19. Name of synagogue
 20. Name of mosque
 21. Name of temple
 22. Name of shrine
 23. Name of altar
 24. Name of statue
 25. Name of idol
 26. Name of deity
 27. Name of spirit
 28. Name of demon
 29. Name of ghost
 30. Name of vampire
 31. Name of witch
 32. Name of wizard
 33. Name of sorcerer
 34. Name of sorceress
 35. Name of magician
 36. Name of magicianess
 37. Name of wizardess
 38. Name of witchess
 39. Name of demoness
 40. Name of ghostess
 41. Name of vampireess
 42. Name of sorceress
 43. Name of sorceress
 44. Name of sorceress
 45. Name of sorceress
 46. Name of sorceress
 47. Name of sorceress
 48. Name of sorceress
 49. Name of sorceress
 50. Name of sorceress

8

STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 DIVISION OF HEALTH

CERTIFICATE OF BIRTH

County of _____
 City of _____
 No. _____
 Name of child _____
 Sex of child _____
 Date of birth _____
 Color of child _____
 Religion of child _____
 Occupation of child _____
 Address of child _____
 Name of mother _____
 Name of father _____
 Name of attending physician _____
 Name of midwife _____
 Name of nurse _____
 Name of doctor _____
 Name of hospital _____
 Name of clinic _____
 Name of school _____
 Name of church _____
 Name of synagogue _____
 Name of mosque _____
 Name of temple _____
 Name of shrine _____
 Name of altar _____
 Name of statue _____
 Name of idol _____
 Name of deity _____
 Name of spirit _____
 Name of demon _____
 Name of ghost _____
 Name of vampire _____
 Name of witch _____
 Name of wizard _____
 Name of sorcerer _____
 Name of sorceress _____
 Name of magician _____
 Name of magicianess _____
 Name of wizardess _____
 Name of witchess _____
 Name of demoness _____
 Name of ghostess _____
 Name of vampireess _____
 Name of sorceress _____
 Name of sorceress _____
 Name of sorceress _____
 Name of sorceress _____
 Name of sorceress _____
 Name of sorceress _____
 Name of sorceress _____
 Name of sorceress _____
 Name of sorceress _____
 Name of sorceress _____

I hereby certify that I attended the birth of this child, who was _____
 (Signature)
 Address _____
 Date _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Oneida Registration District No. 76
City of Stone Idaho Primary Registration District No. 2069
(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 46862
Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Hickman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single
(Write the word.)

6. DATE OF BIRTH

Aug 16 1924
(Month) (Day) (Year)

7. AGE

stillborn
IF LESS than 1 day how many hrs. or min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Stone Idaho

10. NAME OF FATHER

Warren Earl Hickman

11. BIRTHPLACE OF FATHER

(State or Country) Snowville Utah

12. MAIDEN NAME OF MOTHER

Alta Pack

13. BIRTHPLACE OF MOTHER

(State or Country) Millard Co Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. E. Hickman

(Address) Stone Ida

15.

Filed 8-31 1924 J. W. Turner
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 16 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 16 1924 to Aug 16 1924

that I last saw him on Aug 16 1924

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) Yrs. mos. d.

Contributory (Secondary)

(Signed) Edward J. ...

19..... (Address) Snowville Utah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Snowville Utah Aug 16 1924

20. UNDERTAKER ADDRESS

Joe J. Larkine Snowville Utah

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
667-228-039-889
County of Boyer
City of Am. Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED
SEP 8 1924

S

CERTIFICATE OF BIRTH

124781

No. 25 St. Reg. District No. 2072 State File No. 684
Hospital Bethany Deacon Primary Registration District No. 2072 Local Registrar's No. 684
FULL NAME OF CHILD Erma Jacquelin Fox

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? and Number in order of birth 1 Legitimate? yes Date of birth 8 28 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? 1% Sol. Ag. No.

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME John Allen Fox
RESIDENCE American Falls, Ida
COLOR white AGE AT LAST BIRTHDAY 24 (Years)
BIRTHPLACE Idaho
OCCUPATION Electrician

MOTHER
FULL MAIDEN NAME Viola Lillian White
RESIDENCE Am. Falls, Ida
COLOR white AGE AT LAST BIRTHDAY 19 (Years)
BIRTHPLACE Ida
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 9:20 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. , 192

(Signature) V. G. Logan
Physician
(Physician or midwife)

Address Am. Falls, Ida

Filed 9-25-1924 Gruenewald
Registrar.

131

1. The first step in the process of identifying a potential threat is to determine the source of the information. This can be done by reviewing the source's history and reputation, as well as by conducting a background check. Once the source has been identified, the next step is to assess the credibility of the information. This can be done by comparing the information to other sources and by evaluating the source's motives. Finally, the information should be analyzed to determine its potential impact on the organization. This can be done by considering the information's relevance to the organization's mission and by evaluating the potential for harm.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
SEP 8 1924

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Power

City of American Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 25

Primary Registration District No. 2072

City of Bethany Hwy 100 St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 46873

Registered No. 217

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Orma Jacqueline Fox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH August 27 1924
(Month) (Day) (Year)

7. AGE Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Power Co Ida.

10. NAME OF FATHER

John A. Fox

11. BIRTHPLACE OF FATHER

(State or Country) Idaho,

12. MAIDEN NAME OF MOTHER

Vilora Lillian White

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John A. Fox
(Address) American Falls, Idaho

15. Filed 8-29 1924 Benjamin Nott
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 27 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27 1924 to Aug 27 1924 that I last saw her alive on 19 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows: Death in utero. (Still born)

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) W. H. Logan M. D.

August 28 1924 American Falls, Idaho
(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL American Falls, Idaho DATE OF BURIAL Aug 29 1924

20. UNDERTAKER Benjamin Nott ADDRESS Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

294 102-040 553

PLACE OF BIRTH

County of

City of

No.

St.

Hospital

FULL NAME OF CHILD

Registration District No.

Primary Registration District No.

File No.

Registered No.

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

S

Sex of
Child

M

Twin
Triplet
or other?
(To be answered only in event of plural births)

and
Number
in order
of birth

Legiti
mate?

yes

Date of
Birth

May 2

19

24

(Month) (Day) (Year)

FULL
NAME

FATHER
Thomas John Sims

RESIDENCE

Kellogg

COLOR

White

AGE AT LAST
BIRTHDAY

36
(Years)

BIRTHPLACE

England

OCCUPATION

Pump Man

FULL
MAIDEN
NAME

MOTHER
Florence May Nettie

RESIDENCE

Kellogg

COLOR

White

AGE AT LAST
BIRTHDAY

25
(Years)

BIRTHPLACE

England

OCCUPATION

House wife

Number of child of this mother including present birth. Number of children of this mother now living, including present birth. 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born dead, at 6, P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

J. R. Mason

(Physician or midwife)

Given names added from a supplemental report.

19

Registrar

Address

Filed

Registrar

INVESTIGATED FOR BIRMINGHAM

City of _____ No. _____		Registration District No. _____ Primary Registration District No. _____	
FULL NAME OF CHILD _____ _____ _____		Date of Birth _____ (Month) (Day) (Year)	
FULL NAME OF MOTHER _____ _____ _____		Date of Birth _____ (Month) (Day) (Year)	
COLOR _____ BIRTHPLACE _____ OCCUPATION _____		COLOR _____ BIRTHPLACE _____ OCCUPATION _____	
AGE AT LAST BIRTHDAY _____ (Years)		AGE AT LAST BIRTHDAY _____ (Years)	
RESIDENCE _____ _____ _____		RESIDENCE _____ _____ _____	
FULL MAIDEN NAME _____ RESIDENCE _____ COLOR _____ BIRTHPLACE _____ OCCUPATION _____		FULL MAIDEN NAME _____ RESIDENCE _____ COLOR _____ BIRTHPLACE _____ OCCUPATION _____	
Number of children of this mother now living including present child _____ Number of children of this mother who have died _____ DATE OF ATTENDING PHYSICIAN OR MIDWIFE _____ (If living, state date of last visit) _____ (If deceased, state date of death) _____ (Signature) _____ (Physician or Midwife) _____			

863 118 040-275

PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

S

County of ShoshoneCity of TulelogRegistration District No. 123

File No.

124786

No. _____ St.

Primary Registration District No. _____

Registered No.

53

Hospital no

FULL NAME OF CHILD

still born

Sex of Child

MTwin
Triplet
or other?
(To be answered only in event of plural births)

and

Number
in order
of birth1Legiti
mate?yes

Date of Birth

5 18

(Month)

(Day)

24

(Year)

FULL NAME

John A. Holman

FATHER

RESIDENCE

Tulelog

COLOR

White

AGE AT LAST BIRTHDAY

29

(Years)

BIRTHPLACE

Oregon

OCCUPATION

Concrete worker

FULL MAIDEN NAME

Anna Elizabeth Speker

MOTHER

RESIDENCE

Tulelog

COLOR

White

AGE AT LAST BIRTHDAY

23

(Years)

BIRTHPLACE

Missouri

OCCUPATION

House wifeNumber of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born Dead at 9:30 A. M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. P. Hanson

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Filed

8/23/20 E. E. Hardy

Registrar

Registrar

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 123County of Shoshone Primary Registration District No. 516City of Kesey (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby HolmanFile No. 46337
Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)
Single

6. DATE OF BIRTH

May 19
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

John A. Holman

11. BIRTHPLACE OF FATHER

(State or Country) Oregon

12. MAIDEN NAME OF MOTHER

Anna E. Speker

13. BIRTHPLACE OF MOTHER

(State or Country) Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John A. Holman

(Address) _____

15.

Filed 6/21/20 E. E. Hardy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 18 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____, to 19____

that I last saw him alive on 19____

and that death occurred on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

Born Dead.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. R. Mason

M. D.

49 1924 (Address) Kesey, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ In the State _____
yrs. _____ mos. _____ days. yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Kesey, Idaho

DATE OF BURIAL

May 19, 1924

20. UNDERTAKER

McShane

ADDRESS

Kesey, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

367-203 040-799

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

County of

Shoshone

City of

Kellogg

No.

St.

Registration District No.

123

File No.

Hospital

Yes

Primary Registration District No.

Registered No.

58

FULL NAME OF CHILD

Still-born

Sex of Child

F

Twin
Triplet
or other?

and

Number
in order
of birth

4

Legiti
mate?

Yes

Date of Birth

6 3 24

(Month) (Day) (Year)

FULL NAME

FATHER

James Leroy Cox

RESIDENCE

Kellogg

COLOR

White

AGE AT LAST
BIRTHDAY

39

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Electrician

FULL
MAIDEN
NAME

MOTHER

Ruby Bell Price

RESIDENCE

Kellogg

COLOR

White

AGE AT LAST
BIRTHDAY

27

(Years)

BIRTHPLACE

Colo.

OCCUPATION

House wife

Number of child of this mother, including present birth

3

Number of children of this mother now living, including present birth

3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was
on the date above stated.

Born dead

(Born alive or stillborn)

at 6 A. M.

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

J. P. Mason

(Physician or midwife)

Given names added from a supplemental report.

19

Address

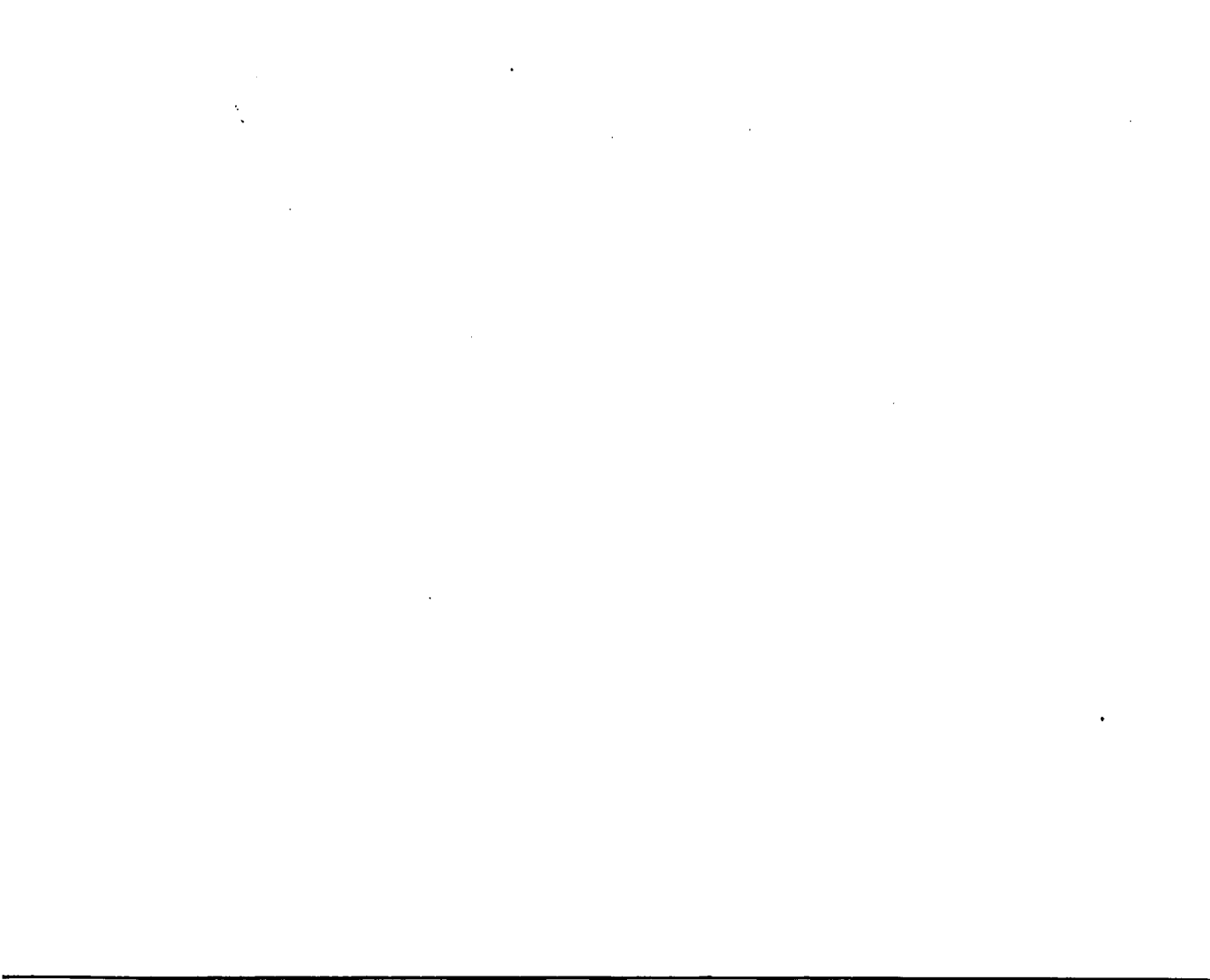
Filed

Sp 2/1924

Registrar

E E Hard

Registrar



WRITE FULLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
436-129 042-255
County of Twin Falls

City of Hansen

No. _____ St. _____ Registration District No. 36 State File No. 124823

Hospital home _____ Primary Registration District No. _____ Local Registrar's No. 61

FULL NAME OF CHILD Albert Kenneth McFarland
(Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? and { Number in order of birth Legitimate? yes Date of birth July 29 192 4
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME A.C. McFarland

RESIDENCE Hansen, Ida.

COLOR W AGE AT LAST BIRTHDAY 30
(Years)

BIRTHPLACE Utah

OCCUPATION farmer

MOTHER
FULL MAIDEN NAME Annie Bennett

RESIDENCE Hansen, Idaho

COLOR W AGE AT LAST BIRTHDAY 20
(Years)

BIRTHPLACE England

OCCUPATION Hw.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at 4 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 192 _____

(Signature)

physician

(Physician or midwife)

Address Kimberly, Idaho

Filed Aug 2 192 4

Registrar.

Registrar.

It is not a question of whether or not the government should be allowed to spend money to conduct research on the health of the population. It is a question of whether or not the government should be allowed to spend money to conduct research on the health of the population.

HT91-103A

STATE OF NEW YORK

2

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LETTERS OF CREDIT

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NOTES: 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840.

NOTES FOR THE RECORD

TESTIMONY OF ATTENDING PHYSICIAN FOR MEDICAL

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[illegible]

References

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19710201

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY Hansen FILE NO. 124823
(ST. DATE OF BIRTH Oct. 17, 1922
(COUNTY Twin Falls SEX OF CHILD Male
FATHER Ambrose C. MOTHER Annie Bennett
(MAIDEN NAME)

I HEREBY CERTIFY that the child herein described has been named:

Albert Kenneth McFarland

SEP 29 1924
BUREAU OF VITAL
STATISTICS

M. A. C. McFarland
Signature of Father or Mother.

the 1990s, the number of people in the world who are under 15 years of age is expected to increase by 1.5 billion, from 1.1 billion in 1990 to 2.6 billion in 2010. The number of people aged 65 and over is expected to increase by 1 billion, from 350 million in 1990 to 1.4 billion in 2010. The number of people aged 15-64 is expected to increase by 1.5 billion, from 2.5 billion in 1990 to 4.0 billion in 2010. The number of people aged 65 and over is expected to increase by 1 billion, from 350 million in 1990 to 1.4 billion in 2010. The number of people aged 15-64 is expected to increase by 1.5 billion, from 2.5 billion in 1990 to 4.0 billion in 2010.

[illegible]

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 36
County of Twin Falls Primary Registration District No. _____
City of Hansen (No. _____, _____ St.)

File No. 16903
Registered No. 16903

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME No name given, McFarland
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (the word.)

6. DATE OF BIRTH July 29 1924
(Month) (Day) (Year)

7. AGE 0 IF LESS than 1 day how many 0 hrs. or 0 mins.
yrs. mos. ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work 0
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER A.C. McFarland

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Annie Bennett

13. BIRTHPLACE OF MOTHER England
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A.C. McFarland
(Address) Hansen, Idaho

15. Filed July 29 1924 J. M. Quinn
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 29 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29 1924 to July 29 1924
that I last saw h. alive on Stillborn 191
and that death occurred on the date stated above, at 4 A.M.
The CAUSE OF DEATH* was as follows:

Prematurity
Six months gestation

(Duration) 0 yrs. 0 mos. 0 ds.
Contributory Placenta Praevia Marginalis
(Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.
(Signed) J. M. Quinn M. D.

7/29 1924 (Address) Kimberlyn Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL cremated DATE OF BURIAL July 29 1924

20. UNDERTAKER none ADDRESS _____

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Twin Falls RECEIVEDCity of Twin Falls SEP 5 1924No. 519-108-042-364 St. Register of BirthsCERTIFICATE OF BIRTH 124836No. 37 State File No. _____Hospital County Primary Registration District No. 1085 Local Registrar's No. _____FULL NAME OF CHILD Harold Vance X

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and { Number in order of birth _____ }	Legitimate? <u>Yes</u>	Date of birth <u>8-8-1924</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth. 2 Number of child of this mother now living, including present birth. 1

FATHER FULL NAME <u>E. L. Vance Jr.</u>	MOTHER FULL MAIDEN NAME <u>Ellen Jane Compton</u>
RESIDENCE <u>Hazelton, Ida.</u>	RESIDENCE <u>Hazelton, Ida.</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>37</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>30</u> (Years)
BIRTHPLACE <u>Selma, Alabama</u>	BIRTHPLACE <u>Meridian, Idaho.</u>
OCCUPATION <u>Civil Engineer</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE *

I hereby certify that I attended the birth of this child, who was Stillborn at 1015 A. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. L. Barry

(Physician or midwife)

Give names added from a supplemental report.

Address Hazelton, Ida.Filed Sept. 1 1924

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

SECRET

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho SEP 11 1924

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place	(<u>CITY Twin Falls</u>	FILE NO.	<u>124836</u>
of	(<u>St. County Hospital</u>	DATE OF BIRTH	<u>*August 8, 1924</u>
Birth	(<u>COUNTY Twin Falls</u>	SEX OF CHILD	<u>Male</u>
FATHER <u>Samuel E. Vance, Jr.</u>		MOTHER <u>Ellen Jane Vance</u>	
		(MAIDEN NAME)	

I HEREBY CERTIFY that the child herein described has been named:

* Harold Vance (Died August 8, 1924)

Samuel E. Vance, Jr.
Signature of Father or Mother.

1. The first part of the report is a general statement of the purpose of the study and the scope of the work.

2. The second part of the report is a description of the methods used in the study.

3. The third part of the report is a description of the results of the study.

4. The fourth part of the report is a discussion of the results of the study.

5. The fifth part of the report is a conclusion.

6. The sixth part of the report is a list of references.

7. The seventh part of the report is a list of appendices.

8. The eighth part of the report is a list of figures.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 46895
Local Registrar's No. 1227

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month ☒)

(Day)

1924
(Year)

Aug 5 1924
(Month) (Day) (Year)

IF LESS than 1
day how many
.....hrs. or
.....min.?

(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business or establishment in which employed (or employer)..... *and 8*

(State or Country)

**11. BIRTHPLACE
OF FATHER**

(State or Country)

12. MAIDEN NAME
OF MOTHER

**13. BIRTHPLACE
OF MOTHER**

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Sent. 1-24 19 1919

17. I HEREBY CERTIFY, That I attended deceased from Aug 8 1974 to Aug 8 1974

that I last saw h. ~~alive~~ on Full moon 19 ,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still birth - dystocia
and prolapse of cord

(Duration) yrs. mos. ds.

**Contributory
(Secondary)**

(Duration) 1 hr. 15 mos. 15 ds.
(Signed) E. C. Burns M. D.
Aug 19 24 (Address) Hazelton, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted? *Ill. Co. Gen. Hosp.*
if not at place of death?
Former or usual residence

19. ~~PLACE OF BURIAL OR REMOVAL~~

DATE OF BURIAL
Aug 9 19 24

26. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 20 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

259 121 042 862
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Twin Falls

City of Twin Falls, Ida.

No. R.F.D. #1 St.

Registration District No. 37

File No.

CERTIFICATE OF BIRTH **124859**

Hospital

Primary Registration District No. 2085

Registered No.

FULL NAME OF CHILD

James Eugene Knight *

(Certificate of no value without full name of child.)

Sex of
Child

male

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

July 21

1924

(To be answered only in event of plural births)

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Argyrol

Number of child of this mother, including present birth

2

Number of child of this mother now living, including present birth

1

FULL
NAME

FATHER
Virgil Knight

FULL
MAIDEN
NAME

MOTHER
Grace Nell Roberts

RESIDENCE

unknown

RESIDENCE

Twin Falls - R.T.

COLOR

white

AGE AT LAST
BIRTHDAY

27

(Years)

COLOR

white

AGE AT LAST
BIRTHDAY

22

(Years)

BIRTHPLACE

Arkansas

BIRTHPLACE

Kansas

OCCUPATION

unknown

OCCUPATION

laundry woman

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was

at 34 M.
(Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

Chas. R. Scott

(Physician or midwife)

Give names added from a supplemental report.

Address

Twin Falls, Ida.

Filed

Sept. 1

1924

John F. Coughlin
Registrar.

Registrar.

8

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsPLACE OF DEATH
County of *Twin Falls*
City of " " "Registration District No. *37*
Primary Registration District No. *2085*
(No. *Twin Falls* *P.O.D.* St.)File No. *46540*
Registered No. *1220*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Knight

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH

July 21 1924
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Twin Falls, Ida

10. NAME OF FATHER

L.H. Knight

11. BIRTHPLACE OF FATHER

(State or Country)

Tenn

12. MAIDEN NAME OF MOTHER

Grace Roberts

13. BIRTHPLACE OF MOTHER

(State or Country)

Kan.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Orlo Williams
Twin Falls

(Address)

15.

Filed Aug. 1-24 19

John F. Longman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 21 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19.

that I last saw h. alive on 19.

and that death occurred on the date stated above, at *34* M.

The CAUSE OF DEATH* was as follows:

Still birth

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Chas. R. Scott M. D.*7-21 1924* (Address) *Twin Falls - Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Twin Falls, Ida**7/21 1924*

20. UNDERTAKER

ADDRESS

*Blue & Staudenmaier**Twin Falls**Ida*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

719 118 001 435
County of AdaCity of BoiseNo. 2519 Idaho St.Hospital St. Lukes

FULL NAME OF CHILD

RECEIVED

STATE OF IDAHO

0012 1924

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

BUREAU OF VITAL

STATISTICS

CERTIFICATE OF BIRTH

124925

S

Registration District No. 2 State File No.Primary Registration District No. 2004 Local Registrar's No. 345

(Certificate of no value without full name of child)

Sex of Child <u>M.</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u> }	Legitimate? <u>yes</u>	Date of birth <u>Sep 18</u> 192 <u>4</u>
(To be answered only in event of plural births)				(Month) (Day) (Year)

What bactericidal solution was used in eyes? Crede Sol.Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME	<u>B.T. Gardner</u>	FULL MAIDEN NAME	<u>Della McNeely</u>
RESIDENCE	<u>Boise Ida</u>	RESIDENCE	<u>Boise</u>
COLOR	<u>w</u>	COLOR	<u>w</u>
AGE AT LAST BIRTHDAY	<u>48</u> (Years)	AGE AT LAST BIRTHDAY	<u>34</u> (Years)
BIRTHPLACE	<u>mo</u>	BIRTHPLACE	<u>Ida</u>
OCCUPATION	<u>Laborer</u>	OCCUPATION	<u>Hw</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 6:10 P M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

Registrar.

Registrar.

1955

WILLARD

CERTIFICATE OF BIRTH

Registration District: 1004
Primary Registration District: 1004

(Certificate of no value without full name of child)

For of Child
and in order of birth
Total number of children born to mother
Date of birth (Month) (Day) (Year)

Number of child of this mother (including those born before and after)

Form with fields: FATHER, MOTHER, FULL NAME, MAIDEN NAME, RESIDENCE, BIRTHPLACE, AGE AT LAST BIRTHDAY, COLOR, AGE AT LAST BIRTHDAY, BIRTHPLACE, OCCUPATION, OCCUPATION.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child who was born on [Date] at [Place] (Signature)
Physician or Midwife
Address
Filed
Registered

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 46934

Registered No. 172

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

St.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many yrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH.

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 18 1924 to Sept 18 1924
that I last saw him alive on 1924

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Stillborn
cause unknown

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

9/18/24 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery

9/19/24

20. UNDERTAKER

ADDRESS

W McBratney

Boise, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH 125031

County of BenedictCity of St. MauriceNo. 331115005-691 St.Registration District No. 32 State File No.Hospital —Primary Registration District No. 2049 Local Registrar's No. 86FULL NAME OF CHILD John

(Certificate of no value without full name of child)

Sex of Child MTwin
Triplet
or other?— } and {
Number
in order
of birthLegiti-
mate? yesDate of
birth 8 151924

(Month) (Day) (Year)

What bactericidal solution was used in eyes? Prologal Sol.Number of child of this mother, including present birth 5Number of child of this mother now living, including present birth 4FULL
NAME

FATHER

Joseph H. Clarke

RESIDENCE

St. Maurice IdaCOLOR WAGE AT LAST
BIRTHDAY 39

(Years)

BIRTHPLACE

Idaho

OCCUPATION

mill manFULL
MAIDEN
NAME

MOTHER

Viola Franklin

RESIDENCE

St. Maurice IdaCOLOR WAGE AT LAST
BIRTHDAY 25

(Years)

BIRTHPLACE

Ark

OCCUPATION

house wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born at St. Maurice on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

A. H. Platt M.D.

(Physician or midwife)

Address

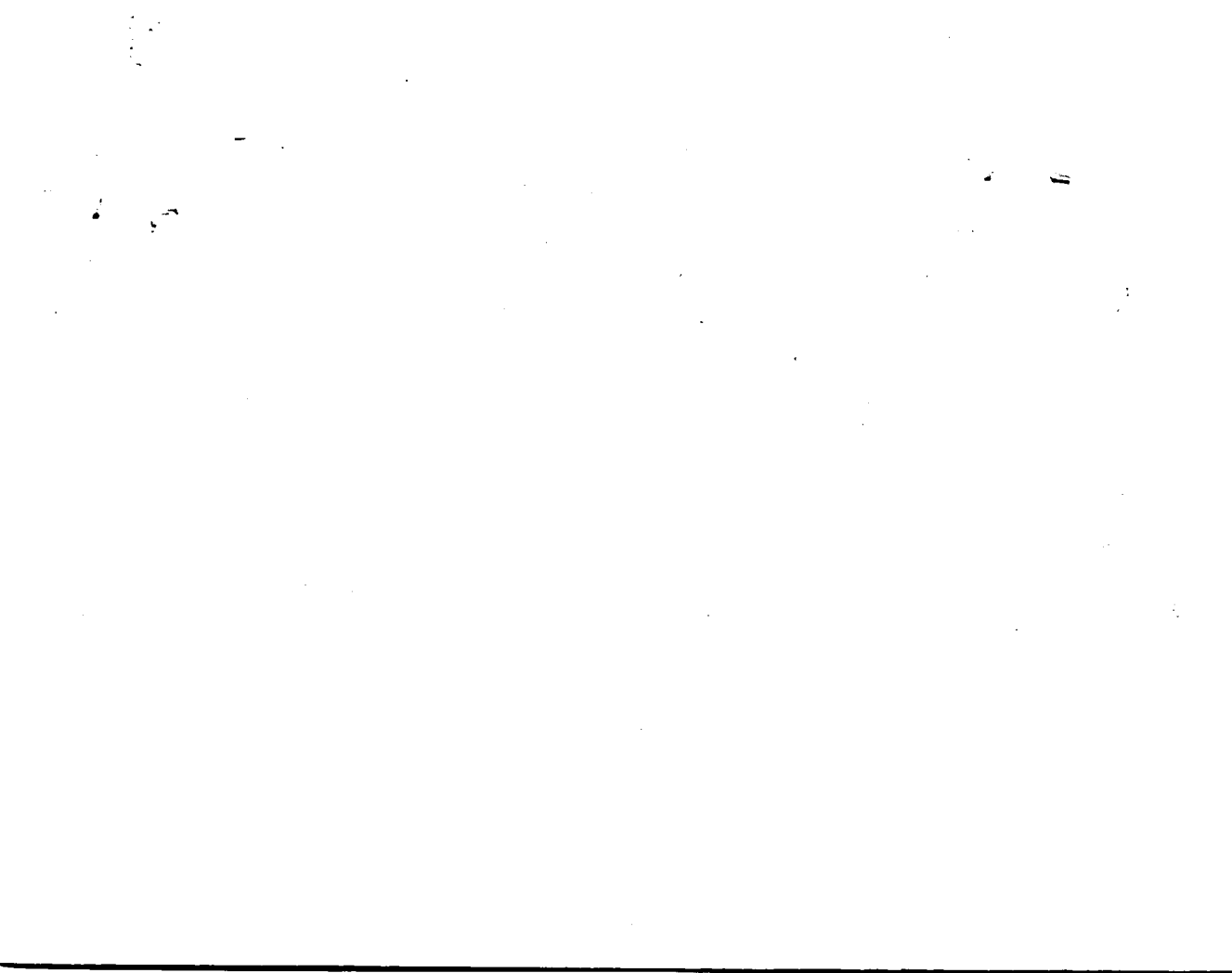
St. Maurice Ida

Filed

Sept 8 1924

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Bennett*
City of *St. Marie*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. *32*
Primary Registration District No. *2049*
(No. *John* St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *46977*
Local Registrar's No. *51*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

7 Aug 15 1924
(Month) (Day) (Year)

7. AGE

Stillborn

IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *St. Marie, Ida*

10. NAME OF FATHER

Joseph N. Clark

11. BIRTHPLACE OF FATHER

(State or Country) *Illinois*

12. MAIDEN NAME OF MOTHER

Viola Franklin

13. BIRTHPLACE OF MOTHER

(State or Country) *Arkansas*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Joseph N. Clark*
(Address) *St. Marie, Ida*

15.

Filed *Aug 18 1924* *Osmerger*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 15 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug 15 1924* to *Aug 15 1924*
that I last saw him alive on *Aug 15 1924*
and that death occurred on the date stated above, at *20* M.

The CAUSE OF DEATH* was as follows:

Still born.
Either by pressure on cord from front of body or detached placenta
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) *✓* yrs. mos. ds.
(Signed) *Over D. Platt* M. D.
Aug 7 1924 (Address) *St. Marie, Ida*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodlawn *8-18 1924*

20. UNDERTAKER

Mitchell & Mearns *St. Marie, Ida*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Bingham

City of Shelby

No. 294 127 006 899

Registration District No. 121

State File No. 125061

Hospital..... Primary Registration District No. 2194 Local Registrar's No. 269

FULL NAME OF CHILD Lorena H. Kimball

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate?	Date of birth <u>June 27, 1924</u> (Month) (Day) (Year)
--------------------------	---	---	-------------	--

What bactericidal solution was used in eyes? Bel Acorn

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 4

FULL NAME <u>Ross A. Kimball</u>	FATHER	FULL MAIDEN NAME <u>Cora Firth</u>	MOTHER
RESIDENCE <u>Firth Idaho</u>		RESIDENCE <u>Firth Idaho</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>32</u>	COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>28</u>
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 2:20 P M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) F. E. Poeth

(Physician or midwife)

Address Shelby Ida

Filed Oct 4 1924 Ms. Walter E. Patric

Registrar.

Registrar.

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

100-443888-100

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of

City of

No.

St.

Register

District No.

State

File No.

Hospital

Primary Registration District No.

Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

male

Twin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

Aug. 9, 1924

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FULL
NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

BIRTHPLACE

OCCUPATION

FULL
MAIDEN
NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ~~born alive~~ Stillborn at 12 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Address

Filed

Registrar.

Registrar.



CONFIDENTIAL

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47012

File No. Mellon
Registered No. 108

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

19 (Address)

DATE OF BURIAL

~~ADDRESS~~

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

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WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

381-217014-387
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Canyon
City of Caldwell Ida

CERTIFICATE OF BIRTH

No. _____ St. Registration District No. 3 State File No. 125129

Hospital _____ Primary Registration District No. 1005 Local Registrar's No. 117

FULL NAME OF CHILD Edith Louise Chadwell

(Certificate of no value without full name of child)

Sex of Child <u>L</u>	Twin Triplet or other? <u>8</u>	and { Number in order of birth <u>6</u>	Legitimate? <u>Yes</u>	Date of birth <u>8/11/1924</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes? 10% Argemol

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 5

FATHER
FULL NAME Charles Chadwell
RESIDENCE Caldwell Ida
COLOR W AGE AT LAST BIRTHDAY 35 (Years)
BIRTHPLACE Lee Co Virginia
OCCUPATION Laborer

MOTHER
FULL MAIDEN NAME Minnie Delphia Cope
RESIDENCE Caldwell Ida
COLOR W AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Hawkins Co Tenn
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn 9 M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 1924

(Signature) M. E. M. D.
(Physician or midwife)

Address Caldwell Ida

Filed Sept. 5 - 1924 John H. Meyers
Registrar.

917 209 014 755
PLACE OF BIRTH

Form V. S. No. 11—20m-7-26-19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED

0018 1924

CERTIFICATE OF BIRTH

S125159

County of CanyonCity of NampaBUREAU OF VITAL
Registration District No. 7File No. 78

No. _____ St. _____

Primary Registration District No. 1006Registered No. 78

Hospital _____

FULL NAME OF CHILD not named

Sex of Child <u>Female</u>	Twin Triplets or other? <u>no</u>	and	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of Birth <u>9-9-24</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

FATHER FULL NAME <u>Enoch K. Klapp</u>	MOTHER FULL MAIDEN NAME <u>Mary Bell Pentecost</u>
RESIDENCE <u>Nampa</u>	RESIDENCE <u>Nampa</u>
COLOR <u>White</u>	COLOR <u>White</u>
AGE AT LAST BIRTHDAY <u>36</u> (Years)	AGE AT LAST BIRTHDAY <u>29</u> (Years)
BIRTHPLACE <u>Iowa</u>	BIRTHPLACE <u>Kansas</u>
OCCUPATION <u>Bridge Foreman</u>	OCCUPATION <u>House Wife</u>

FATHER FULL NAME <u>Enoch K. Klapp</u>	MOTHER FULL MAIDEN NAME <u>Mary Bell Pentecost</u>
RESIDENCE <u>Nampa</u>	RESIDENCE <u>Nampa</u>
COLOR <u>White</u>	COLOR <u>White</u>
AGE AT LAST BIRTHDAY <u>36</u> (Years)	AGE AT LAST BIRTHDAY <u>29</u> (Years)
BIRTHPLACE <u>Iowa</u>	BIRTHPLACE <u>Kansas</u>
OCCUPATION <u>Bridge Foreman</u>	OCCUPATION <u>House Wife</u>

Number of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Still Born on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) D. P. Meredith

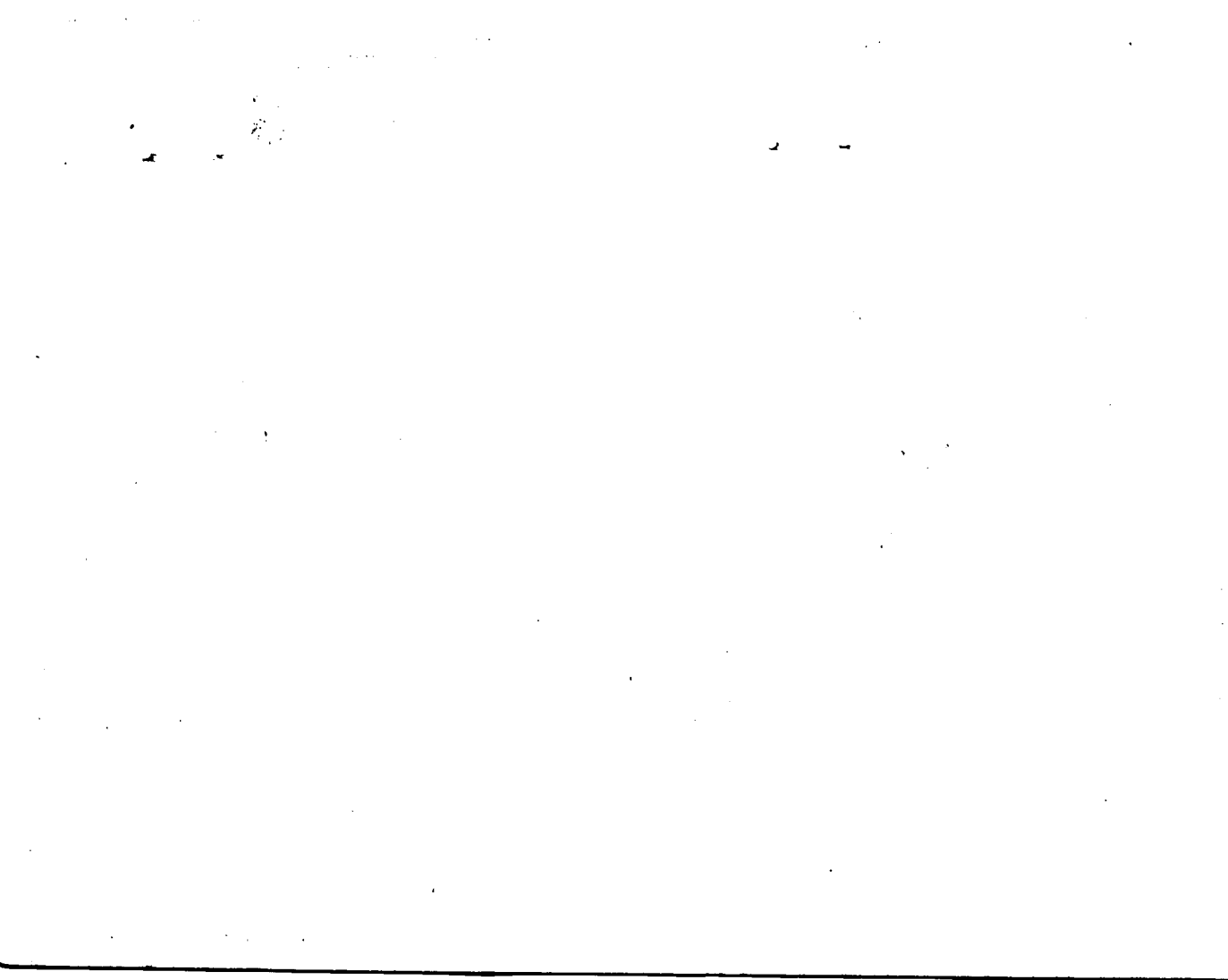
(Physician or midwife)

Given names added from a supplemental report.

Address NampaFiled Sept 30 1924

Registrar.

Registrar. Mac Kerby



A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

363-231 019-859
PLACE OF BIRTH

Form V. S. No. 11-C-2887-21-19

STATE OF IDAHO

BUREAU OF VITAL STATISTICS

County of CusterRECEIVED
SEP 26 1924

CERTIFICATE OF BIRTH

S125190

City of MacRegistration District No. 76File No. 231

No. _____ St. _____

Primary Registration District No. 2153

Registered No. _____

Hospital _____

FULL NAME OF CHILD _____

Sex of Child <u>Female</u>	Twin Triplet or other? <u>(To be answered only in event of plural births)</u>	and	Number in order of birth _____	Legitimate? <u>yes</u>	Date of Birth <u>July 27</u> 19 <u>24</u> (Month) (Day) (Year)
----------------------------	---	-----	--------------------------------	------------------------	---

FATHER
FULL NAME Herchel H CollinsRESIDENCE MacKayCOLOR white AGE AT LAST BIRTHDAY 27 (Years)BIRTHPLACE MoOCCUPATION BankerMOTHER
FULL MAIDEN NAME Jugate HermanRESIDENCE MacKay IdaCOLOR white AGE AT LAST BIRTHDAY 24 (Years)BIRTHPLACE IdaOCCUPATION House wifeNumber of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born at 745a M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Carroll J. Jensen

(Physician or midwife)

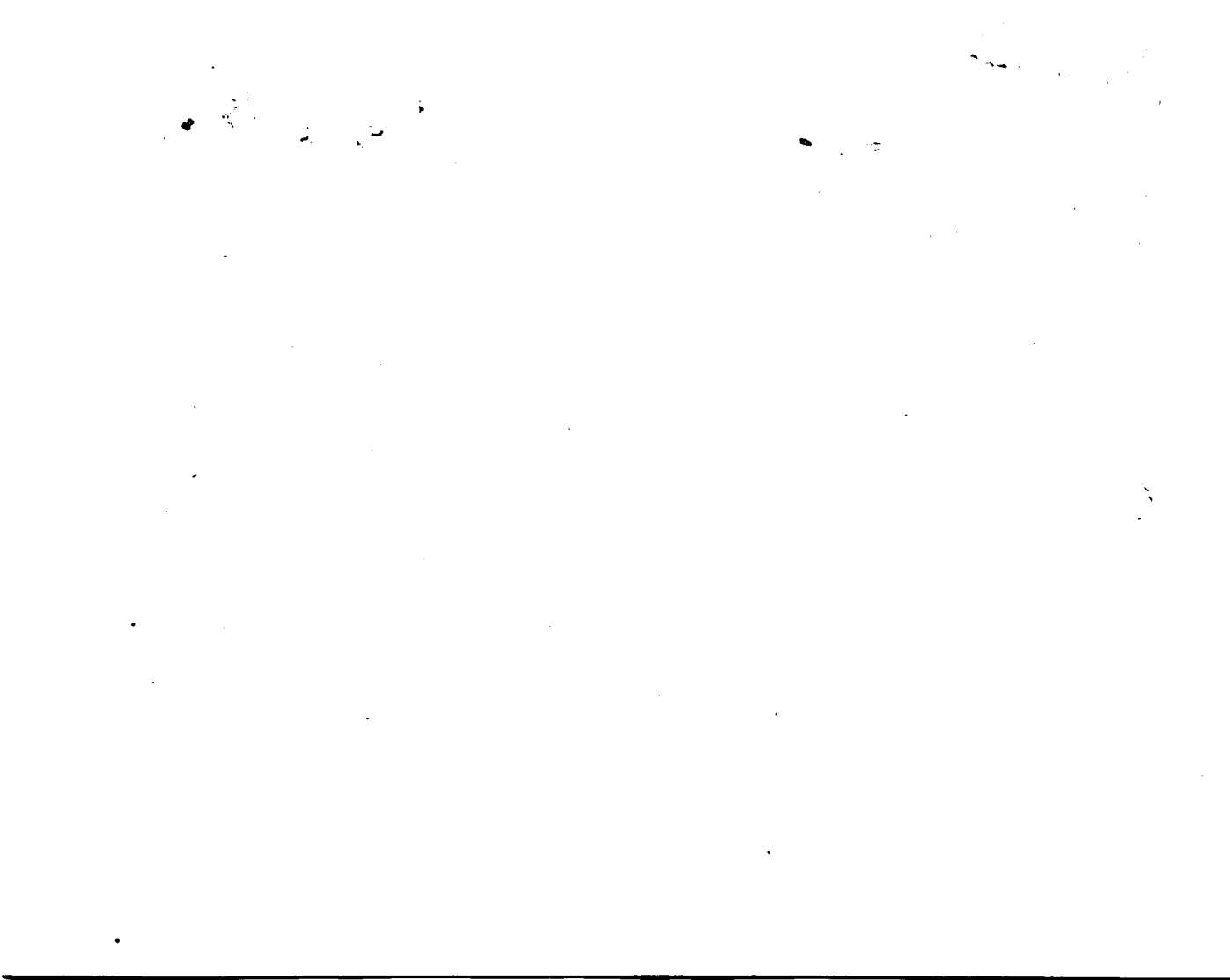
Given names added from a supplemental report.

19

Address MacKay IdaFiled Sept 27 1924 Nowacki

Registrar

Registrar



FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

47043

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Custer
City of MalakoffRegistration District No. 76Primary Registration District No. 2153File No. 17

Registered No. _____

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Female whiteInfant
(Print the word.)

6. DATE OF BIRTH.

July 31 1924
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....Infant

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERH. H. Collins11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho12. MAIDEN NAME
OF MOTHERJugab Herman13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Dr. C. A. Hansen

(Address)

Malakoff Ida

15.

Filed

Sept. 27 1924

Local Registrar

16. DATE OF DEATH

July 31 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 31 1924 to July 31 1924that I last saw h— alive on July 31 1924

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Premature separation of
Placenta
Still Born.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Carroll Hansen M. D.19 (Address) Malakoff Ida.*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important, Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of FranklinCity of MustonNo. 849-121-021-354Registration District No. 27State File No. 125198Hospital Primary Registration District No. 2119 Local Registrar's No. 211

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u>3</u> }	Legitimate? <u>yes</u>	Date of birth <u>Sept 21</u> 192 <u>4</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes? Number of child of this mother, including present birth 3Number of child of this mother now living, including present birth 2

FULL NAME

FATHER

Len Hurst

RESIDENCE

Muston Idaho

COLOR

white

AGE AT LAST

BIRTHDAY

27
(Years)

BIRTHPLACE

Malad A. Idaho

OCCUPATION

Farmer

FULL MAIDEN NAME

MOTHER

Aptan Lemman

RESIDENCE

Muston Idaho

COLOR

white

AGE AT LAST

BIRTHDAY

22
(Years)

BIRTHPLACE

Muston Idaho

OCCUPATION

House keeper

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 5 A M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 1924

Registrar.

(Signature)

Thos B Holder
Physician
(Physician or midwife)

Address

Muston Idaho

Filed

Oct 4, 1924
A. H. Cheller

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

THIS IS A PRELIMINARY REPORT AND NOT A FINAL REPORT. IT IS SUBJECT TO CHANGE AND SHOULD NOT BE USED FOR ANY PURPOSE OTHER THAN FOR THE INFORMATION OF THE BUREAU OF VITAL STATISTICS.

STATE OF IDAHO
BUREAU OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH 12512

Registration District No. _____ State of Idaho

Primary Registration District No. _____ Registrar's No. _____

FULL NAME OF CHILD

(Certificate of no value without this name)

Sex of Child _____ Date of Birth _____
 { and { Number of Birth _____
 { of Birth _____
 (The number only in case of plural births)

Was medical solution used in case?

Number of child of this mother, including present birth _____
 Number of child of this mother now living, including present birth _____

FATHER	MOTHER
NAME	NAME
RESIDENCE	RESIDENCE
COLOR	COLOR
AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY
BIRTHPLACE	BIRTHPLACE
OCCUPATION	OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____

as the above stated.
 I have seen no attending physician or midwife, and the mother has no other record of this birth. A child born at home with no other record of this birth, and no other evidence of the mother's birth, is considered a non-report.

(Signature of midwife)

Address _____

Phone _____

Signature _____

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

959707 021' 366

County of Franklin

City of Preston

No. _____ St. _____

Hospital _____

FULL NAME OF CHILD

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE -
1924 BUREAU OF VITAL STATISTICS

BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

125204

Registration District No. 27

File No. _____

Primary Registration District No. 2119

Registered No. 220

Carl Love

(Certificate of no value without full name of child.)

Sex of Child male

Twin
Triplet
or other?
(To be answered only in event of plural births)

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

9 7

1924

What bacterioidal solution was used in eyes? Argyrol

Number of child of this mother, including present birth... 9

Number of child of this mother now living, including present birth... 6

FULL
NAME

P. F. Love

FATHER

RESIDENCE

Preston Idaho

COLOR

w

AGE AT LAST
BIRTHDAY

39

(Years)

BIRTHPLACE

Utah

OCCUPATION

Farmer

FULL
MAIDEN
NAME

Belen Coords

MOTHER

RESIDENCE

Preston Idaho

COLOR

w

AGE AT LAST
BIRTHDAY

39

(Years)

BIRTHPLACE

Utah

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was, Stillborn on the date above stated.

at 7:50 PM.

(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

E. S. Milford

Physician

(Physician or midwife)

Give names added from a supplemental report.

Address

Preston Idaho

Filed

Oct. 4 1924

A. R. Culler

Registrar.

Registrar.

8-

1000

1000

1000

2

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

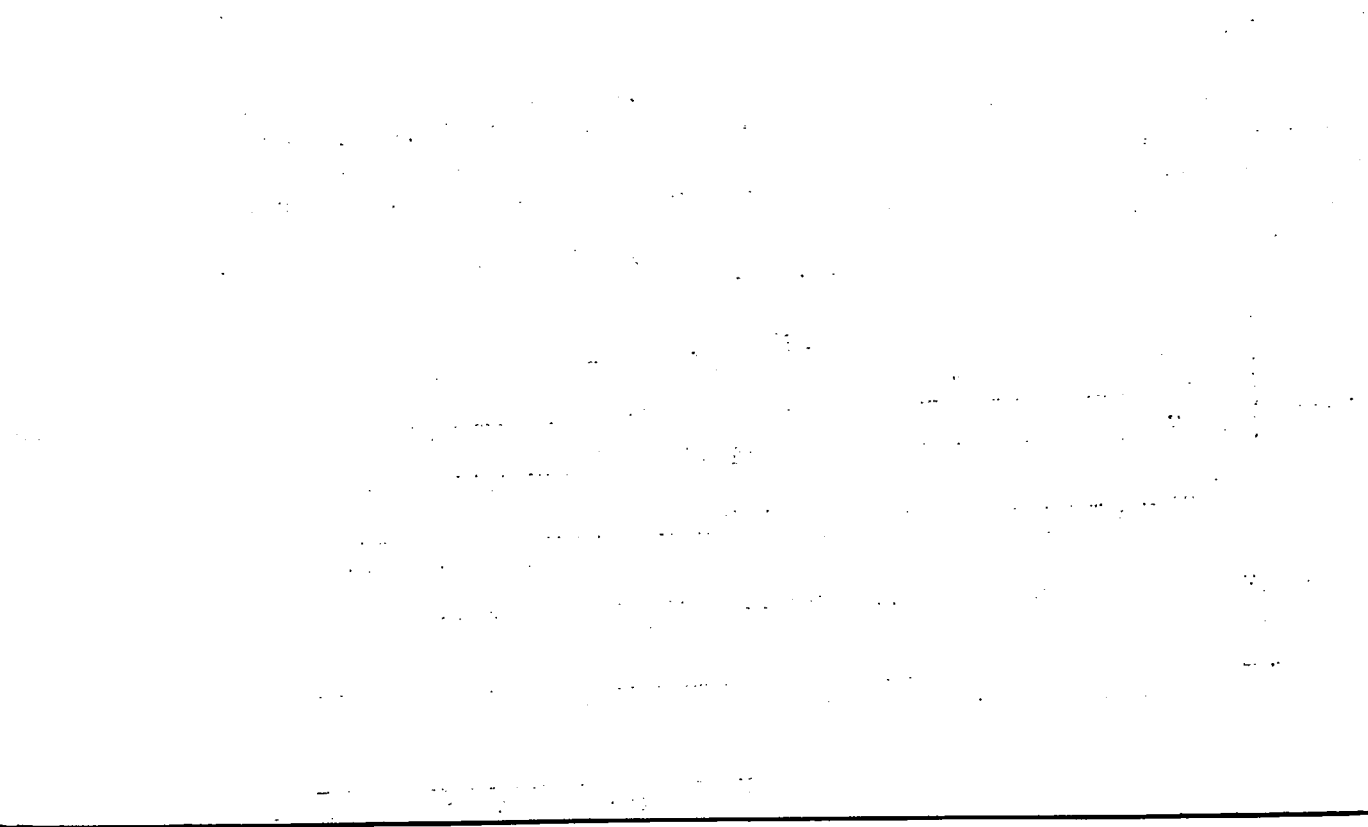
* * * * *

Place of Birth (CITY Mapleton FILE NO. 125204
 (ST. _____ DATE OF BIRTH Sept 7
 (COUNTY Franklin SEX OF CHILD Male
 FATHER Perry Floyd Irie MOTHER Ellen Coombs
 (MAIDEN NAME)

I HEREBY CERTIFY that the child herein described has been named:

Child was still born Carl

Mrs Ellen Irie
 Signature of Father or Mother



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO	
765-207 023-981		DEPARTMENT OF PUBLIC WELFARE	
County of <u>Jersey</u>		BUREAU OF VITAL STATISTICS	
City of <u>Emmett</u>		CERTIFICATE OF BIRTH	
No.	St. <u>Registration District</u> No. <u>6</u>	125226	
Hospital		Local Registrar's No.	
FULL NAME OF CHILD <u>No name</u>		(Certificate of no value without full name of child)	
Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u> { Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>9-7-1924</u> (Month) (Day) (Year)
What bactericidal solution was used in eyes? <u>none</u>			
Number of child of this mother, including present birth <u>2</u>		Number of child of this mother now living, including present birth <u>1</u>	
FATHER		MOTHER	
FULL NAME <u>Bruce Clarence Zove</u>		FULL MAIDEN NAME <u>Mary Margaret Ryan</u>	
RESIDENCE <u>Emmett</u>		RESIDENCE <u>Emmett</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>40</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)
BIRTHPLACE <u>Nebraska</u>		BIRTHPLACE <u>Oregon</u>	
OCCUPATION <u>Tram Conductor Ry</u>		OCCUPATION <u>House wife</u>	
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*			
I hereby certify that I attended the birth of this child, who was <u>Stillborn</u> at <u>10:30 a. M.</u> on the date above stated.			
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.			
Give names added from a supplemental report., 192....			
Address <u>Emmett</u>		Filed <u>9-7-1924</u>	
Registrrar.		Registrrar.	

RETURN TO STATIONER

Hospital _____
 Primary Registration District No. _____
 Registration District No. _____
 Local No. _____

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-10-2001 BY 60322 UCBAW

[illegible]

It was determined that the following information was used in 1964:

Number of child of this mother now living, including present birth

RENTON

NAME
ADDRESS
CITY

陳國治

JUN 1964

RECEIVED

COPIES

NEAL PA NEA
YACHTING

2000年12月15日

818TH PL

VICTARUSSO

MEYER, RUSSELL

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I learned early that I attended the birth of this child, who was

(47834012)

(encl 10 to 104-1048)

20070101

1. The first step in the process of the investigation is the identification of the problem. This is done by the investigator who is assigned to the case. The investigator will then gather information about the problem and the people involved. This information will be used to develop a plan of action.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 47052

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 6
Precinct Registration District No. 6
(No. St.)
Infant

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Sept 7 1924
(Month) (Day) (Year)

7. AGE

Infant

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Wm. J. Jones

11. BIRTHPLACE OF FATHER

(State or Country)

Nebr

12. MAIDEN NAME OF MOTHER

Wm. J. Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 1-8-1924

J. H. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 7 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

at birth 191 to 191

that I last saw him alive not at all 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still Born. Had died in utero some days before as decomposition had begun
(Duration) yrs. mos. ds.

Contributory (Secondary)

Do not know cause
(Duration) yrs. mos. ds.

(Signed)

J. H. Reynolds M. D.
9-8-1924 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted, If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Emmett Cemetery 9-8-1924

20. UNDERTAKER ADDRESS

Emmett

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemen, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED
OCT 9 1924
BUREAU OF VITAL STATISTICS

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Idaho

City of Huspatio

No. 265-22105 946 St.

Registration District No. 103

File No. 125252

Hospital

Primary Registration District No. 2181

Registered No. 57

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>9-21-1924</u> (Month) (Day) (Year)
----------------------------	------------------------------------	--	------------------------	--

(To be answered only in event of plural births)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME Ludwig Konrad
RESIDENCE Huspatio Ida
COLOR White AGE AT LAST BIRTHDAY 38 (Years)
BIRTHPLACE Austria
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Lottie Ruff
RESIDENCE Huspatio Ida
COLOR White AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Wash.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 2 P. M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) B. Chipman
Physician
(Physician of midwife)

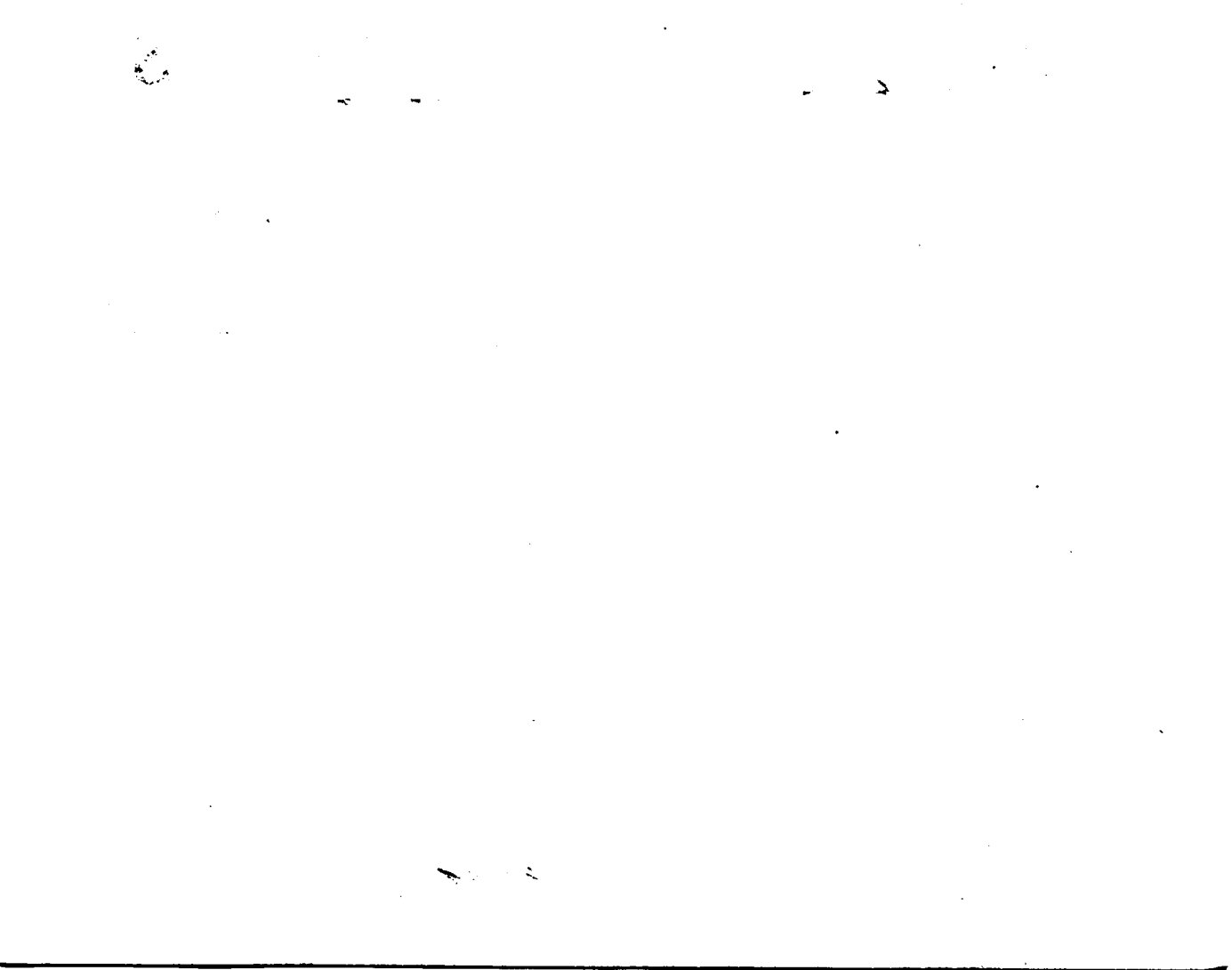
Give names added from a supplemental report.

Address Wengerle Ida

Filed Oct 1 1924 G. S. Stickins

Registrar.

Registrar.



CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

Registration District No.

Registration District No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
-
- (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

24

9.8.8ücklin

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....

that I last saw h..... alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Premature separation
of Placenta
(Duration)..... Yrs..... mos..... ds.Contributory
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

20. UNDERTAKER

DATE OF BURIAL

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Registrar.

PLACE OF BIRTH

DEPARTMENT OF THE ARMY
BUREAU OF MILITARY INTELLIGENCE

2152504

No. _____
Primary Registration District No. _____
Local Registrar's No. _____

CLASS OF MAY 1961

(Certificate of no value without full name of child)

(1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33) (34) (35) (36) (37) (38) (39) (40) (41) (42) (43) (44) (45) (46) (47) (48) (49) (50) (51) (52) (53) (54) (55) (56) (57) (58) (59) (60) (61) (62) (63) (64) (65) (66) (67) (68) (69) (70) (71) (72) (73) (74) (75) (76) (77) (78) (79) (80) (81) (82) (83) (84) (85) (86) (87) (88) (89) (90) (91) (92) (93) (94) (95) (96) (97) (98) (99) (100)

It has been suggested that the use of the word "bacterial" is not appropriate in this context.

11-11-61

FULL NAME: WILLIAM J. MOHRER
 FULL NAME: WILLIAM J. MOHRER
 FULL NAME: WILLIAM J. MOHRER
 FULL NAME: WILLIAM J. MOHRER

RECEIVED

AGENCY USE

1946 Y (1946 Y) BIRTHDAY (BIRTHDAY)

BIRTHPLACE *W. J. ...*
 BIRTHPLACE *W. J. ...*

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE *

is available how new child will be paid at between 1 and three years I

There were no other persons on the last night.

can to follow the other, however, should make this return.

(Physician or Nurse)

199100A

100-443887-1000

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

RECEIVED CERTIFICATE OF DEATH

Registration District No.

Registration District No.

(No. of State)

47061

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19.

that I last saw h. alive on 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

623-109 028 867
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

BUREAU OF VITAL
STATISTICS

CERTIFICATE OF BIRTH

County of Goodwin

City of Boise

No. 315 Garden St.

Registration District No. 30

State File No. 125321

Hospital Boise

Primary Registration District No. 105

Local Registrar's No. 110

FULL NAME OF CHILD

Infant Osterberg

(Certificate of no value without full name of child)

Sex of
Child

M.

Twin
Triplet
or other?

and { Number
in order
of birth

8

Legiti-
mate?

yes

Date of
birth

9

1924

(To be answered only in event of plural births)

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 8

Number of child of this mother now living, including present birth 5

FULL
NAME

FATHER

John Osterberg

RESIDENCE

Boise, Idaho

COLOR

white

AGE AT LAST
BIRTHDAY

42
(Years)

BIRTHPLACE

Sweden

OCCUPATION

Mill man

FULL
MAIDEN
NAME

MOTHER

Gottilda Dorothy Hogberg

RESIDENCE

Boise, Idaho

COLOR

white

AGE AT LAST
BIRTHDAY

37
(Years)

BIRTHPLACE

Sweden

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3:30 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Dr. Dwyer

(Physician or midwife)

Give names added from a supplemental report.

Address

Filed

10/2 1924 D. B. Brennan

Registrar.

Registrar.

Primary Registration District No. 47 Local Registrar's No. 10

(Certification of no value without this name of child)

Number of } and }
in order of }
to which }
(to be answered only in event of change)

100-443887-100

FATHER

804301233

COL 105

BIRTHPLACE

NOT A GUNDO

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

at 11:00 p.m. I passed early that I attended the birth of this child. who was

on the date above stated.

There are no attempts to identify or interview the other board members. A subpoena would make this easier. It should be noted that the other board members are not listed in the other files.

(U) Number added from common code

7-10-1963

ଉପସ୍ଥାପନା

4040

(Physician or Midwife)

(911185812)

Butter

These are the names of each in order of

NOV 11 1964

1. The Commission has the honor to acknowledge the receipt of your letter of the 11th of June 1928, in which you inform us that you have been appointed to the position of Vice-President of the American Society of International Law.

1. PLACE OF DEATH

County of Kootenai
 City of Coeur d'Alene

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. 30
 Primary Registration District No. 1051 St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 47075
 Registered No. 1438

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single

(Write the word.)

6. DATE OF BIRTH

9 9 1924
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Q 13 24 D. L. Brennan
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 9 24
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 9 1924 to Sept. 9 1924

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still born - premature infant

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Sept. 10 24 (Address) Coeur d'Alene Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest-Cem. Coeur d'Alene 9-10 1924

20. UNDERTAKER

ADDRESS

Classed Coeur d'Alene

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

462-104029-235

PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-24m-23-17

CERTIFICATE OF BIRTH

County of.....

City of.....

No.....St.

Hospital.....

FULL NAME OF CHILD.....

Registration District No.....

Primary Registration District No.....

File No.....

Registered No.....

Sex of Child

231

Twin
Triplet
or other

and { Number
in order
of birth

(To be answered only in event of plural births)

Legitimate?

yes

Date of Birth

Apr 4 1924
(Month) (Day) (Year)

FULL NAME

Paul Masse

FATHER

FULL MAIDEN NAME

Ida H. Stevens

MOTHER

RESIDENCE

Geneva

RESIDENCE

Geneva

COLOR

W

AGE AT LAST BIRTHDAY

42
(Years)

COLOR

W

AGE AT LAST BIRTHDAY

28
(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Idaho

OCCUPATION

Plumber

OCCUPATION

Housewife

Number of child of this mother, including present birth.....

Number of children of this mother now living, including present birth.....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was..... at..... M.
on the date above stated.

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature).....

(Born alive or stillborn)

(Physician or midwife)

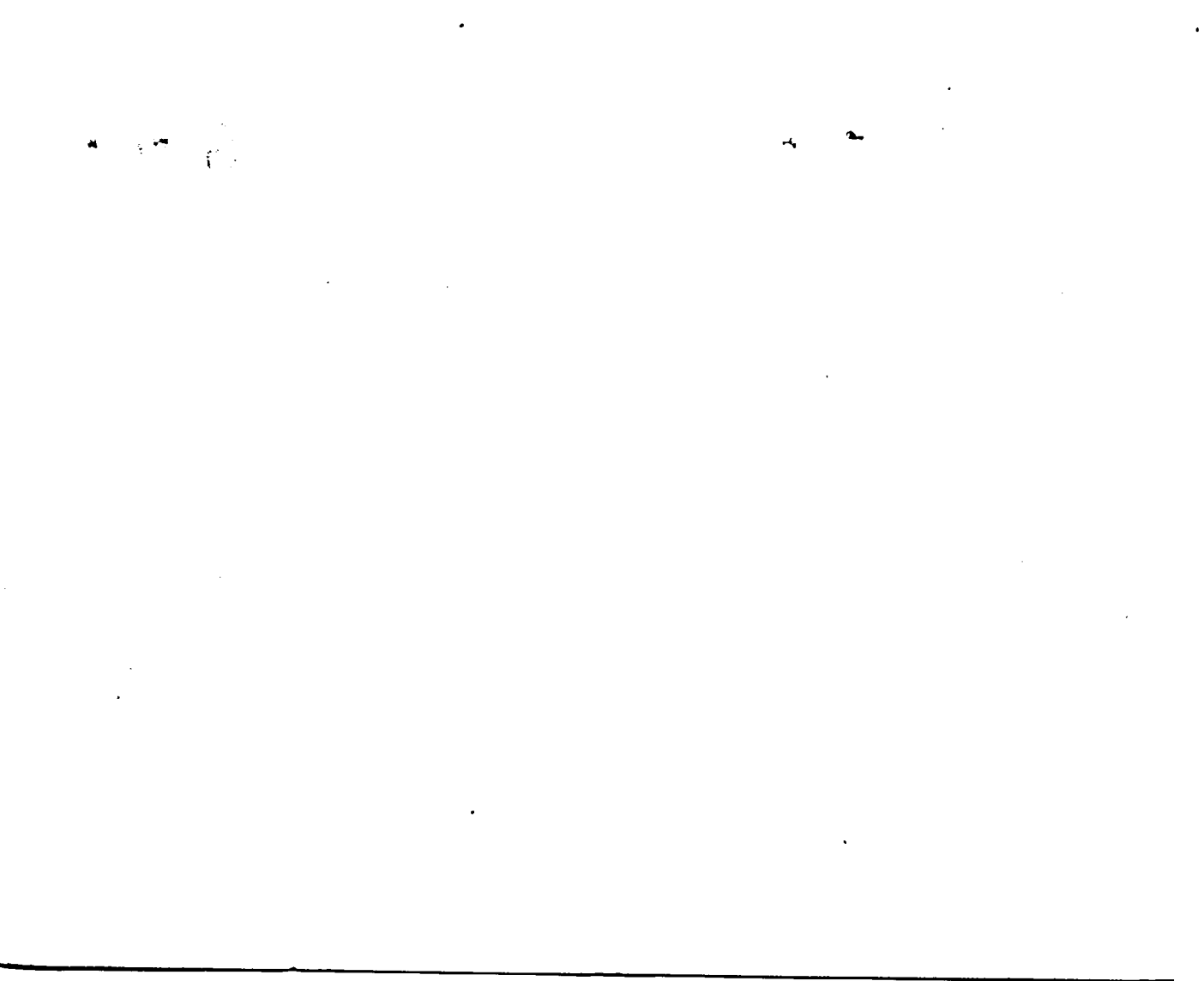
Given names added from a supplemental report.

Address.....

Filed.....

Registrar

Registrar



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH Latah Registration District No. 5-2
County of Latah Primary Registration District No. 2-42
City of BURAU (Id.) St. Idaho
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Steve Birch

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 46805
Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH Aug 4 1924
(Month) (Day) (Year)

7. AGE _____ IF LESS than 1 day how many _____ hrs. or _____ min. ?
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Genoa
(State or Country)

10. NAME OF FATHER Paul Masse

11. BIRTHPLACE OF FATHER minn
(State or Country)

12. MAIDEN NAME OF MOTHER Ada H Stevens

13. BIRTHPLACE OF MOTHER North
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Paul Masse
(Address) McGowan Lane

15. Filed 8-6 19 24 W. H. C. C. C.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 4 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____, that I last saw h_____ alive on _____ 19____, and that death occurred on the date stated above, at _____ M. The CAUSE OF DEATH* was as follows:

Died in utero

(Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary)

(Duration) _____ mos. _____ ds.

(Signed) W. H. C. C. C. M. D.

19 24 (Address) Genoa

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Private Cemetery DATE OF BURIAL 8-4-24

20. UNDERTAKER Paul Masse ADDRESS McGowan Lane

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, &c.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

243-105-079-413
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 125362

County of Latah

City of Museau

No. _____ St. _____

Registration District No. 61

File No. _____

Hospital _____

Primary Registration District No. 2141

Registered No. 105

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>8/1/24</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------	-----------------------------	--

What bacteriocidal solution was used in eyes? _____

Number of child of this mother, including present birth... 8 Number of child of this mother now living, including present birth... 4

FULL NAME <u>Clarke</u>	FATHER <u>Butler</u>
RESIDENCE <u>Museau</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>46</u> (Years)
BIRTHPLACE <u>Mo</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Catherine</u>	MOTHER <u>Mentley</u>
RESIDENCE <u>Museau</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>44</u> (Years)
BIRTHPLACE <u>MO</u>	
OCCUPATION <u>House wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____ at _____ M.
on the date above stated. (Respective or stillborn)

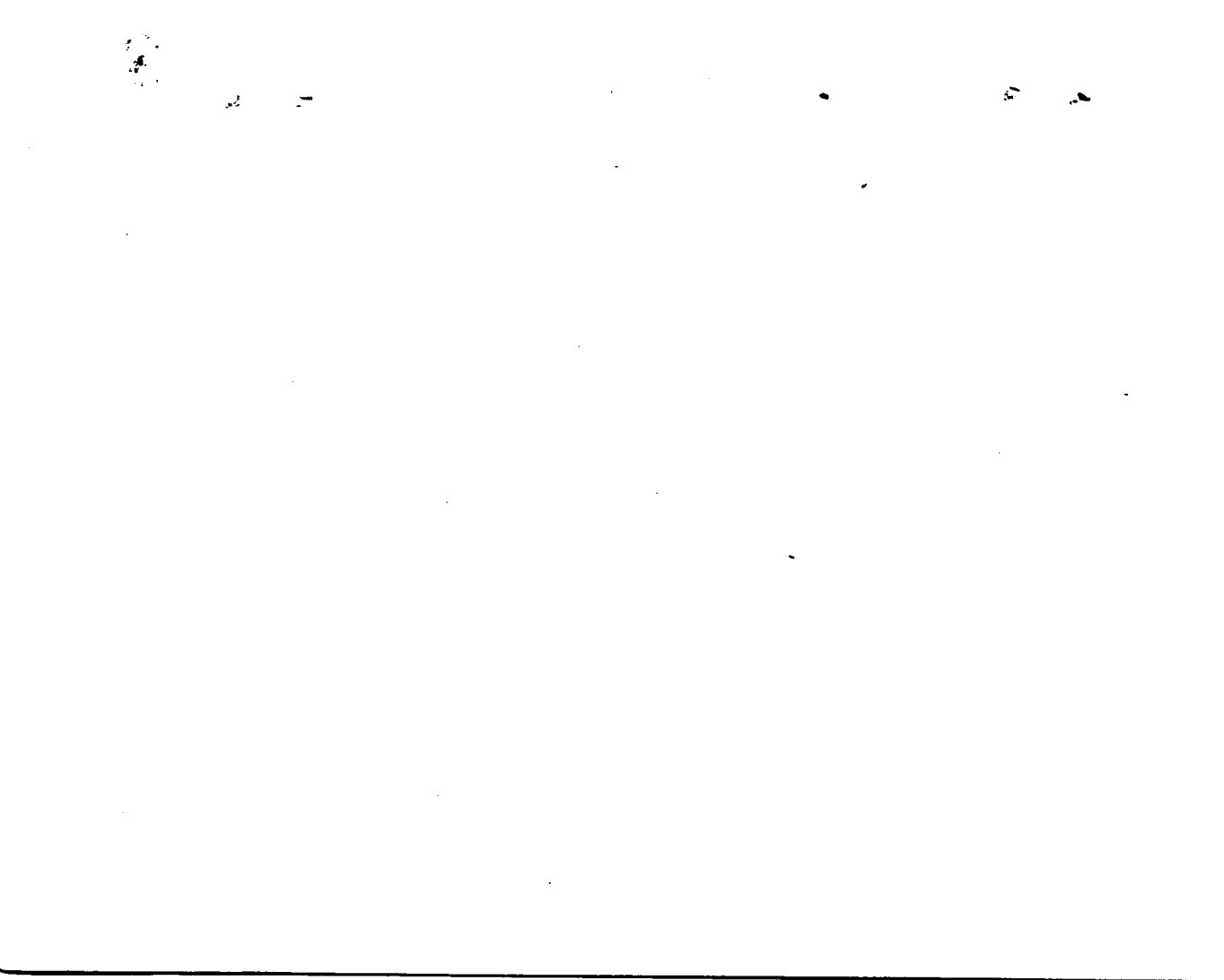
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. N. Clarke
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address _____
Filed Oct 2 1924 M. H. Baughers
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 47089
Registered No. 46

1. PLACE OF DEATH.
County of Latah
City of Moscow
Registration District No. 101
Primary Registration District No. 2111
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Butler

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Child
(Write the word.)

6. DATE OF BIRTH
Sept. 5 1924
(Month) (Day) (Year)

7. AGE Stillborn
IF LESS than 1 day
how many yrs. mos. ds. hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Child
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER Clark Butler

11. BIRTHPLACE OF FATHER
(State or Country) Mo.

12. MAIDEN NAME OF MOTHER Katherine Matley

13. BIRTHPLACE OF MOTHER
(State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clark Butler
(Address) Moscow Rt. 5

15. Filed Sept. 5 1924
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Sept. 5 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191 that I last saw h alive on 191 and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:
Still born (8 more babies)

(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. N. Clarke M. D.
(Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Moscow Sept. 5 1924

20. UNDERTAKER ADDRESS
H.R. Short Moscow

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

266 227 035 433
PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

No. 11-C-25m-7-21-19

County of Nez Perce

City of Lewiston

Registration District No. 96

File No. 1254

No. _____ St. _____

Primary Registration District No. 1009

Registered No. _____

Hospital St Joseph's

FULL NAME OF CHILD

Bowers

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate? <u>yes</u>	Date of Birth <u>Aug 27</u> 19 <u>24</u> (Month) (Day) (Year)
----------------------------	---	-----	--------------------------------	-------------------------------	--

FATHER
FULL NAME Lloyd Bowers
RESIDENCE Lewiston, Idaho
COLOR White
AGE AT LAST BIRTHDAY 32 (Years)
BIRTHPLACE Oregon
OCCUPATION Cement Worker

MOTHER
FULL MAIDEN NAME Nona Mc Cartney
RESIDENCE Lewiston, Idaho
COLOR White
AGE AT LAST BIRTHDAY 24 (Years)
BIRTHPLACE Montana
OCCUPATION Housewife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was Stillborn at 3:30 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

John H. Alley

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Lewiston, Idaho

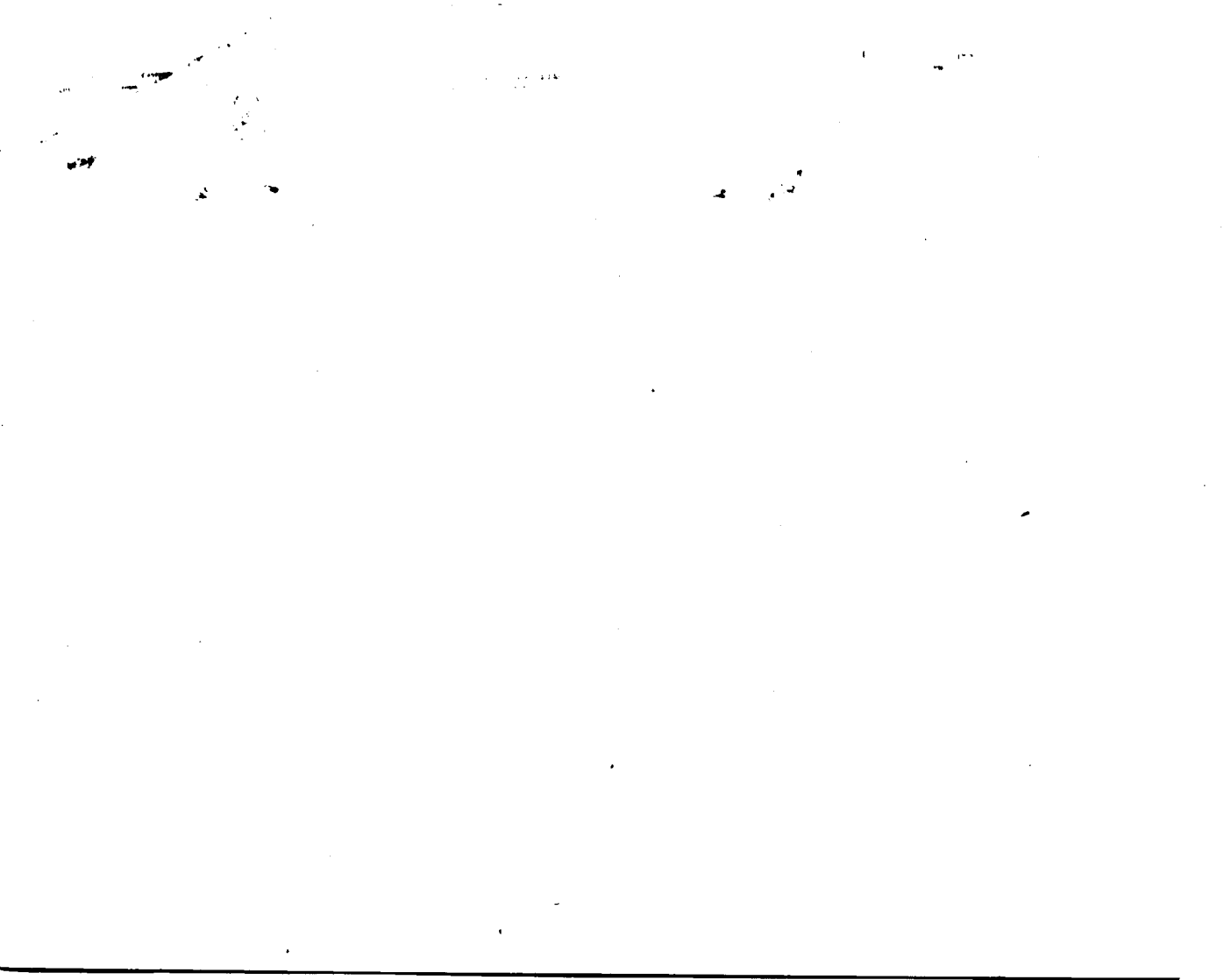
Filed

Sept-8 1924

Arson E Bruce

Registrar

Registrar



CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96County of MyerPrimary Registration District No. 1009City of Lewiston(No. 1 St.)File No. 46846Registered No. 46846

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn Bower

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MWhiteInfant
(Write the word)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Lewiston Ida.

10. NAME OF FATHER

Lloyd Bower

11. BIRTHPLACE OF FATHER

(State or Country)

Ida.

12. MAIDEN NAME OF MOTHER

Rona Mc Cartney

13. BIRTHPLACE OF MOTHER

(State or Country)

Mont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lloyd Bower

(Address)

Lewiston Ida

15.

Filed

Sept 7 1924Arson E. Brun
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 17 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 18 1924 to Aug 18 1924that I last saw h. Stillborn alive on Aug 18 1924and that death occurred on the date stated above, at ✓ M.

The CAUSE OF DEATH was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

John B. Alley M. D.

19

(Address) Lewiston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Ida.Aug 15 1924

20. UNDERTAKER

ADDRESS

Vassar Undertaking Co. Lewiston Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary); may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

791-228-042-291
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of *Twin Falls*

City of *Twin Falls*

CERTIFICATE OF BIRTH

125509

No. _____ St. _____ Registration District No. *37* State File No. *125509*

Hospital _____ Primary Registration District No. *1085* Local Registrar's No. _____

FULL NAME OF CHILD

Not named
(Certificate of no value without full name of child)

Sex of Child <i>Female</i>	Twin Triplet or other? <i>None</i>	and { Number in order of birth	Legitimate? <i>Yes</i>	Date of birth <i>9 28 1924</i>
(To be answered only in event of plural births)				(Month) (Day) (Year)

What bactericidal solution was used in eyes? *None*

Number of child of this mother, including present birth *8* Number of child of this mother now living, including present birth *5*

FATHER
FULL NAME *Earl Sawville*
RESIDENCE *Twin Falls Ida.*
COLOR *White* AGE AT LAST BIRTHDAY *41* (Years)
BIRTHPLACE *Kansas*
OCCUPATION *Housekeeping*

MOTHER
FULL MAIDEN NAME *Mattie Braum*
RESIDENCE *Twin Falls Ida.*
COLOR *White* AGE AT LAST BIRTHDAY *46* (Years)
BIRTHPLACE *Indiana*
OCCUPATION *Housekeeping*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *Stillborn* at *2:45* P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature)

W. H. Pike
Physician
(Physician or midwife)

Address

Twin Falls Ida.

Filed Oct. 1 1924

John F. Houghlin
Registrar.

Registrar.

THIS IS A CERTIFICATE OF BIRTH FOR THE CHILD OF THE MOTHER AND FATHER NAMED ABOVE. IT IS THE DUTY OF THE REGISTRAR TO RECORD THE BIRTH OF EVERY CHILD BORN IN THE STATE OF ILLINOIS. THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE LAW. IT IS THE DUTY OF THE REGISTRAR TO RECORD THE BIRTH OF EVERY CHILD BORN IN THE STATE OF ILLINOIS. THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE LAW.

PLACE OF BIRTH

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

152500

County of

City of

No.

Hospital

FULL NAME OF CHILD

Sex of

Child

What pathological condition was used in case?

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FATHER

MOTHER

RESIDENCE

RESIDENCE

COLOR

COLOR

AGE AT LAST BIRTHDAY (Year)

AGE AT LAST BIRTHDAY (Year)

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born at

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. Give names of those from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 37
 County of Twin Falls Primary Registration District No. 1085
 City of Twin Falls (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Granville

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 47152

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Infant
 (Write the word.)

6. DATE OF BIRTH Sept 28 1924
 (Month) (Day) (Year)

7. AGE 0 Yrs. 0 Mos. 0 ds. IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of the industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) Kansas

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl Granville

(Address) Twin Falls

15.

Filed Oct. 1-24 1924

Local Registrar John F. Coughlin

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 28 1924
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 1924 _____ 1924

that I last saw him/her alive on _____ 1924

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Placental infarction

_____ (Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. G. Pipe

9/28/24 (Address) Twin Falls, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Twin Falls

DATE OF BURIAL

Sept 29 1924

20. UNDERTAKER

J. C. Smith

ADDRESS

Twin Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

RECORD
THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

918-181-601-619
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

--S--

County of Ada NOV 7 1924
City of Mendian
No. R # 1 St. Registration District No. State File No. 125574
Hospital Primary Registration District No. 11 Local Registrar's No. 56
FULL NAME OF CHILD Clifford Madsen
(Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? and { Number in order of birth } Legitimate? yes Date of birth 10 11 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4

FATHER
FULL NAME Andrew Madsen
RESIDENCE Mendian # 1
COLOR white AGE AT LAST BIRTHDAY 38
(Years)
BIRTHPLACE Utah
OCCUPATION farmer

MOTHER
FULL MAIDEN NAME Sarah E. Farmer
RESIDENCE Mendian # 1
COLOR white AGE AT LAST BIRTHDAY 35
(Years)
BIRTHPLACE Utah
OCCUPATION at home

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive Stillborn at 3:50 a. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

J. F. Neal
Physician
(Physician or midwife)

Address

Mendian Idaho

Filed

Nov 11 1924

Registrar.

Registrar

in the
field?

JOHN W. WILSON

[REDACTED] (b) (7) (C), (b) (7) (D)
 [REDACTED] (b) (7) (C), (b) (7) (D)
 [REDACTED] (b) (7) (C), (b) (7) (D)
 [REDACTED] (b) (7) (C), (b) (7) (D)

Date of Birth _____

512.1748

35A-947942

NOTATION

CELESTICA IS OF ATTENDING REASON FOR ME WITH

[illegible]

1871

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho _____

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY Meridian, Id.
(ST. _____
(COUNTY Ada Co.

FILE NO. 125574

DATE OF BIRTH Oct 11 1924

SEX OF CHILD Male

FATHER Arthur Madsen

MOTHER Sadie Farmer
(MAIDEN NAME)

I HEREBY CERTIFY that the child herein described has been named:

RECEIVED
DEC 1 1924

Clifford Madsen

Sadie Madsen
Signature of Father or Mother.

DEC 20 1973

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

CERTIFICATE OF DEATH 47196

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Ada

City of Murphy

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1-10

Primary Registration District No. 9-10
(No. 10 St.)

State File No. 34

Local Registrar's No. 50

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Billy Madison

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

white

Single
(Write the word)

6. DATE OF BIRTH

Oct 11 1924
(Month) (Day) (Year)

7. AGE

✓ Yrs. ✓ Mos. ✓ ds. ✓

IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. ✓
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Ada Co. Idaho

10. NAME OF FATHER

Andrew Madison

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Sarah Farmer

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Andrew Madison

(Address) Murphy, Idaho

15.

Filed Oct 15 1924 Omer Jackson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 11 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

✓ 1924 to ✓ 1924

that I last saw him ✓ alive on ✓ 1924

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

12m dead

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. H. Mad

M. D.

10/11/1924 (Address) Murphy, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Star Cemetery

DATE OF BURIAL

Oct 15 1924

20. UNDERTAKER

None

ADDRESS

DEC 20 1973

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **20 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

469-212.000-689
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

125613

County of Bannock RECEIVED NOV 17 1924
City of Idaho CERTIFICATE OF BIRTH
No. _____ St. _____ Registration District No. 88 State File No. _____
Hospital _____ Primary Registration District No. 2160 Local Registrar's No. 66
FULL NAME OF CHILD Leed
(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and { Number in order of birth _____ }	Legitimate? <u>yes</u>	Date of birth <u>Oct-12-1924</u> (Month) (Day) (Year)
----------------------------	------------------------------	--	------------------------	--

What bactericidal solution was used in eyes? None
Number of child of this mother, including present birth 1st Number of child of this mother now living, including present birth None

FATHER
FULL NAME W. A. Morrison
RESIDENCE Idaho
COLOR White AGE AT LAST BIRTHDAY 35 (Years)
BIRTHPLACE Franklyn, Idaho
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Louise White
RESIDENCE Idaho
COLOR White AGE AT LAST BIRTHDAY 23 (Years)
BIRTHPLACE Pestis, Wis.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 2 30 M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 192_____
Registrar.

(Signature) A. J. Hartshorn

(Physician or midwife)
Address Idaho
Filed Nov 10 1924 Ernest C. Coffin
Registrar.

THE UNIVERSITY OF CHICAGO

1. The first step in the process of the development of the new system is the selection of the appropriate technology. This is a critical decision, as it will determine the scope and scale of the project. The selection process should take into account the current state of the technology, the needs of the organization, and the available resources.

[illegible]

SECRET

DECLASSIFIED BY 6032
ON 08-29-2017

100-443887-100

REGISTER

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho

NOV 28 1924

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place
of
Birth

(CITY
(ST.
(COUNTY

Downey
Calif.
Barnstable

FILE NO.

125613

DATE OF BIRTH

Oct 12, 1924

SEX OF CHILD

Female

FATHER

William

MOTHER

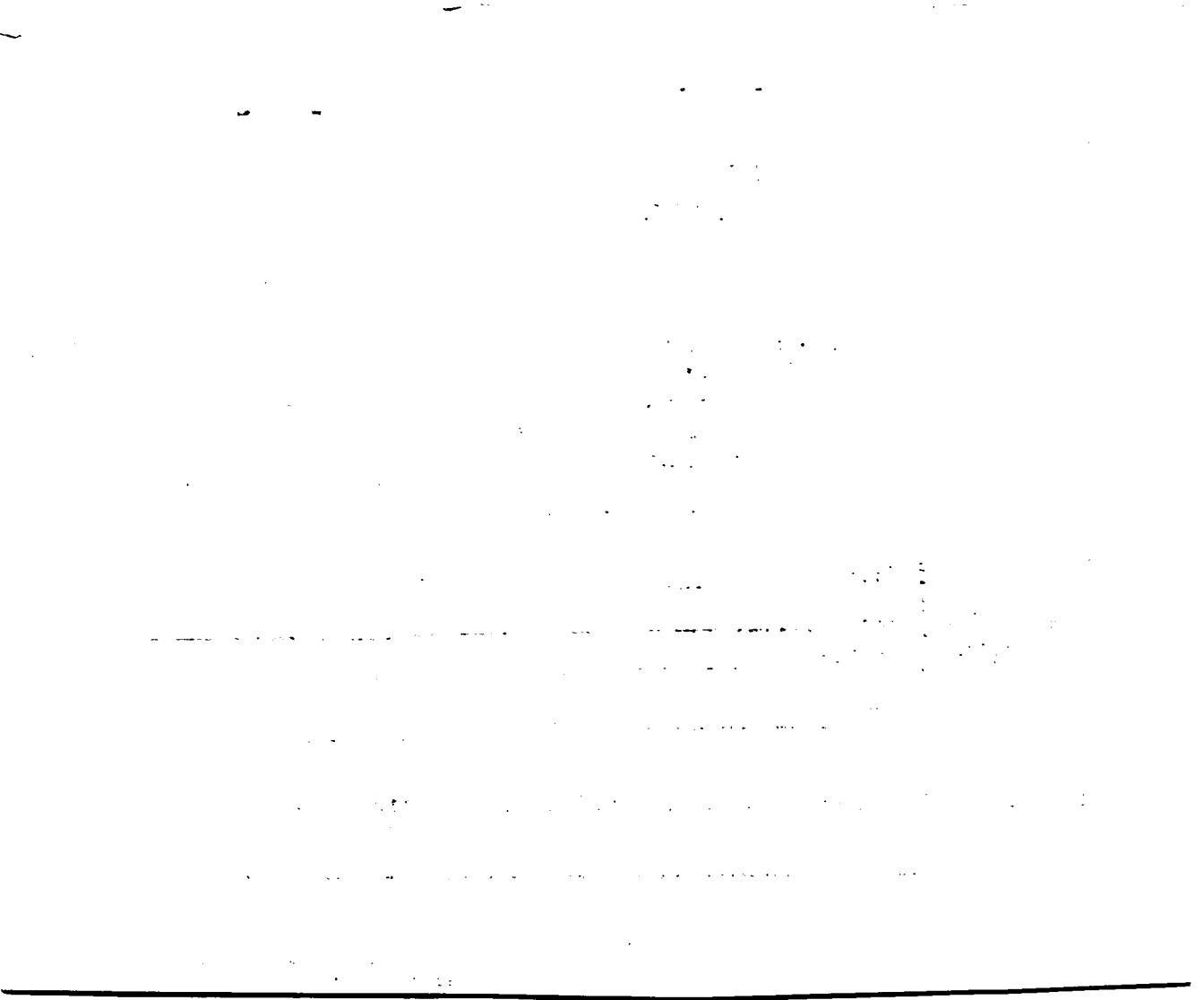
Louise O. Schultz
(MAIDEN NAME)

I HEREBY CERTIFY that the child herein described has been named:

Died with a name

RECEIVED
NOV 28 1924
BUREAU OF VITAL

Mrs. W. A. Morrison
Signature of Father or Mother.



RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Bannock*
City of *Pawney*Registration District No. *83*
Private Registration District No. *2160*
(No. St.)File No. *47233*
Registered No. *12*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-OWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH

Oct - 12 - 1924
(Month) (Day) (Year)

7. AGE

0 Yrs. *0* Mos. *0* ds.IF LESS than 1 day
how many *0* hrs.
or *0* min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Pawney, Idaho*

10. NAME OF FATHER

W. A. Morrison

11. BIRTHPLACE OF FATHER

(State or Country) *Franklin, Ida*

12. MAIDEN NAME OF MOTHER

Louise White

13. BIRTHPLACE OF MOTHER

(State or Country) *Pestida Wis.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. A. Morrison

(Address)

Pawney, Idaho

15.

Filed

*No. 10**1924**Mary C. Coffin*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct - 12 - 1924
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Oct - 12 - 1924*, to *Oct, 12, 1924*, that I last saw h..... alive on..... 19....., and that death occurred on the date stated above, at *2:39* A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth(Duration) Yrs. mos. ds.
Contributory *Six months Gestation*
(Secondary)(Duration) yrs. mos. ds.
(Signed) *A. H. Hartigan* M. D.*10-13-1924* (Address) *Pawney Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Marsh Center, Ida**10-13-1924*

20. UNDERTAKER

ADDRESS

None

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name or gin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

251-209.003-251
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Blaine City of Pocatello
No. 650 No. 7 St. Registration District No. 28 State File No. 125625
Hospital St. Anthony's Primary Registration District No. 2101 Local Registrar's No. 11619
FULL NAME OF CHILD Stillborn
(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? and { Number in order of birth } Legitimate? Yes Date of birth Aug 9 - 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Silver nitrate 1%
Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 2

FATHER		MOTHER	
FULL NAME	<u>Frank B. Edward Keating</u>	FULL MAIDEN NAME	<u>Larsh Mary Knable</u>
RESIDENCE	<u>735 Wilson Ave. No. Poc.</u>	RESIDENCE	<u>735 Wilson Ave. No. Poc.</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>33</u> (Years)	AGE AT LAST BIRTHDAY	<u>33</u> (Years)
BIRTHPLACE	<u>Grand Rapids, Minn.</u>	BIRTHPLACE	<u>Sioux Falls, S. D.</u>
OCCUPATION	<u>Electrician - R.R.</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 4:45 P.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 1924

(Signature) Asm. Newton M.D.
(Physician or midwife)

Address Pocatello
Filed 1924

Registrar.

Registrar

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Pima*
 City of *Goetzville*

Registration District No.

Primary Registration District No.

(No.)

If death occurs away from
 usual residence, give facts
 called for under special in-
 formation.

2. FULL NAME

Infant / Kerting

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hos-
 pital, institution or camp,
 give its NAME instead of
 street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Female White*

(Write the word.)

6. DATE OF BIRTH

Aug 9 1924

7. AGE

Still Born

If LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J. E. Kerting

11. BIRTHPLACE OF FATHER

(State or Country)

Dakota

12. MAIDEN NAME OF MOTHER

Dorah Knable

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. E. Kerting(Address) *1735 Wilson*

15.

Filed

9/15 1924

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 9 1924

17. I HEREBY CERTIFY, That I attended deceased from

Aug 9 1924 to *Aug 9 1924*
 that I last saw him alive on *Aug 9 1924*
 and that death occurred on the date stated above, at *3:30 P.M.*

The CAUSE OF DEATH* was as follows:

Premature birth probably the result of a low grade malarial infection. Period of gestation about 6 months.

Contributory (Secondary)

Child only lived a few minutes

(Signed)

R. M. Newton

M. D.

Aug 9 1924 (Address) *Castillo, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Mountain View**Aug 9 1924*

20. UNDERTAKER

ADDRESS

Schumacher Trans Co

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

432-207-003-866
PLACE OF BIRTH

STATE OF IDAHO

S

County of Bannock RECEIVED DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

City of Pocatello OCT 7 8 1924 CERTIFICATE OF BIRTH 125640

No. 650 No. 7th St. Registration District No. 28 State File No. 6634

Hospital St. Anthony's Primary Registration District No. 161 Local Registrar's No. 6634

FULL NAME OF CHILD Doris Mae Kenzie Hillborn
(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Sept. 7</u> 192 <u>4</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	-----------------------------	--

What bactericidal solution was used in eyes? Agnes 3170

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Wilbert Lee Mc Kenzie</u>	<u>720 So. 9th Ave.</u>	<u>Manda Vidella Howe</u>	<u>720 So. 9th Ave.</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)
BIRTHPLACE <u>Great Falls, Montana</u>		BIRTHPLACE <u>Rigby, Idaho</u>	
OCCUPATION <u>Dentist</u>	<u>"Head"</u>	OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive. } at 59 M.
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 192____

(Signature) OK Call md
Carlson Buehler
(Physician or midwife)

Address Pocatello
Filed 19/ 1924

Registrar.

RECEIVED BY THE BUREAU OF THE INSPECTION OF THE DEPARTMENT OF THE INTERIOR
 OFFICE OF THE INSPECTOR GENERAL
 WASHINGTON, D. C.

THIS REPORT WAS PREPARED BY THE BUREAU OF THE INSPECTION OF THE DEPARTMENT OF THE INTERIOR
 OFFICE OF THE INSPECTOR GENERAL
 WASHINGTON, D. C.

REPORT MADE BY THE BUREAU OF THE INSPECTION OF THE DEPARTMENT OF THE INTERIOR
 OFFICE OF THE INSPECTOR GENERAL
 WASHINGTON, D. C.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

DATE OF BIRTH

PLACE OF BIRTH

(Signature)

Address

(Signature of Mother)

OCCUPATION

MARRIAGE

COLOR

WEIGHT AT BIRTH

NOTES

Number of child of this mother

DAY OF THE WEEK

COLOR

MARRIAGE

OCCUPATION

Number of child of this mother

Place of birth of mother

(Certificate of birth without fee)

DATE

TIME

(Place of birth of mother)

DATE

TIME

Place of birth of mother

Place of birth of mother

Place of birth of mother

2

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of *Bannock* Registration District No. *28*

City of *Pocatello* (Primary Registration District No. *2161*)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Doris M. McKenzie

State File No. *47222*

Local Registrar's No. *4427*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

(Write the word)

6. DATE OF BIRTH

Sept 7 1924
(Month) (Day) (Year)

7. AGE

Skilled
IF LESS than 1 day how many hrs. or min.?
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Bannock County*

10. NAME OF FATHER

Wilbert L. McKenzie

11. BIRTHPLACE OF FATHER

(State or Country) *Canada*

12. MAIDEN NAME OF MOTHER

Manda Howe

13. BIRTHPLACE OF MOTHER

(State or Country) *Rigby, Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Howe*

(Address) *Rigby Idaho*

15.

Filed *9-7-24* Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 7 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 7 1924
that I last saw him alive on *Sept 7 1924*
and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Skilled
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. L. O'Connell M. D.

1924 (Address) *Pocatello, Idaho*
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. mos. days. In the State... yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

mt View

DATE OF BURIAL

9-7-24

20. UNDERTAKER

McHan and Co

ADDRESS

Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

419-122-003-235
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bennett

OCT 18 1924

BUREAU OF VITAL STATISTICS

City of Postville

CERTIFICATE OF BIRTH 125659

No. 28 St. Registration District No. 28 State File No. 6654

Hospital Postville Primary Registration District No. 2141 Local Registrar's No. 6654

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child <u>M</u>	Twin Triplet or other? <u> }</u> and { Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>9-22</u> <u>1924</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes? ✓

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Allen J. Maretta
RESIDENCE Postville Idaho
COLOR wht AGE AT LAST BIRTHDAY 21 (Years)
BIRTHPLACE Wisconsin
OCCUPATION Machinist

MOTHER
FULL MAIDEN NAME Mabel Stewart
RESIDENCE same
COLOR wht AGE AT LAST BIRTHDAY 19 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at Postville on the date above stated. 9:40 P. M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) D C Ray

(Physician or midwife)

Address Postville, Idaho

Filed 10/1 1924

Registrar.

Registrar.

DATE AT LAST
BIRTHDAY

COLOUR
BIRTHPLACE

OCCUPATION

COLOUR
BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child who was born on the 10th day of the month of January 1911 at the residence of the mother at the place of birth of the child.

(Signature)

(Signature)

Address

On the 10th day of the month of January 1911, I attended the birth of this child who was born at the residence of the mother at the place of birth of the child. I hereby certify that I attended the birth of this child who was born on the 10th day of the month of January 1911 at the residence of the mother at the place of birth of the child.

1

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 28
 County of Bannock Registration District No. 2101
 City of Pocatello (No. 28) St. General Hospital

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Marttie

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 47205
 Registered No. 4437

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
 (Write the word.)

6. DATE OF BIRTH September 22 1924
 (Month) (Day) (Year)

7. AGE stillborn IF LESS than 1 day
 how many..... hrs.
 or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Pocatello

10. NAME OF FATHER

Allen Marttie

11. BIRTHPLACE OF FATHER

(State or Country)

Wis

12. MAIDEN NAME OF MOTHER

Mabel Stuart

13. BIRTHPLACE OF MOTHER

(State or Country)

Ogden Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Allen Marttie
 (Address) Pocatello

15. Filed 9-23 1924

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 22 1924
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to Sept 22 1924
 that I last saw him alive on 19
 and that death occurred on the date stated above, at M.
 The CAUSE OF DEATH* was as follows:

Still birth.
dead when 8 days
due to cord around neck

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

D. C. Ray

M. D.

9-23 1924

(Address)

Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mountain View Bur

DATE OF BURIAL

Sept 23 1924

20. UNDERTAKER

Schumacher & Hall

ADDRESS

Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

144-217-003-813
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock
City of Pocatello

CERTIFICATE OF BIRTH 125667

No. _____ St. _____ Registration District No. 28 State File No. _____
Hospital General Primary Registration District No. 5161 Local Registrar's No. 6647

FULL NAME OF CHILD Valencia Clare Emmundsen

(Certificate of no value without full name of child)

Sex of Child F. Twin - Triplet - or other? - and { Number in order of birth - } Legitimate? yes Date of birth 9-17 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Edward Emmundsen
RESIDENCE Pocatello
COLOR W. AGE AT LAST BIRTHDAY 31
(Years)
BIRTHPLACE Pocatello
OCCUPATION H. W. Clerk.

MOTHER
FULL MAIDEN NAME Ruth Hall
RESIDENCE Pocatello
COLOR W AGE AT LAST BIRTHDAY 26
(Years)
BIRTHPLACE Nebraska
OCCUPATION N. W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 4 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) [Signature]

(Physician or midwife)

Address Pocatello

Filed 10/1 1924

Registrar.

Registrar.

2
DEPARTMENT OF HEALTH AND WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF MARRIAGE

No. _____ State File No. _____

Hospital _____ Local Registrar _____

FILE NAME OF CHILD

(Indicate if no value without full name of child)

Box of _____ and _____
 (Indicate if no value without full name of child)
 Date of _____
 (Month) (Year)

What bacteriological solution was used in case?

Number of child of this mother including previous birth _____

FATHER **MOTHER**
 FULL NAME FULL NAME
 RESIDENCE RESIDENCE

BIRTHDAY **BIRTHDAY**
 AGE AT LAST BIRTHDAY AGE AT LAST BIRTHDAY

BIRTHPLACE **BIRTHPLACE**
 (State) (State)

OCCUPATION **OCCUPATION**

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I solemnly certify that I attended the birth of this child, who was _____ at _____

When there was no attending physician or midwife, then the father, husband, or mother, or other person, who was present at the birth of the child, is to sign this certificate, and to sign the report of the attending physician or midwife.

(Signature)

(Physician or midwife)

Address _____

File _____

THIS CERTIFICATE IS TO BE FILED IN THE BUREAU OF VITAL STATISTICS, DEPARTMENT OF HEALTH AND WELFARE, STATE OF NEW YORK, AT THE OFFICE OF THE COMMISSIONER OF HEALTH, ALBANY, NEW YORK.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V, S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bonneville
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 28
Primary Registration District No. 2161
(No. General Hospital)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 47227
Local Registrar's No. 4432

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Patricia Claire Amundsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH Sept. 17 1924
(Month) (Day) (Year)

7. AGE Still born
IF LESS than 1 day how many hrs. or min.?
— Yrs. — Mos. — ds. —

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Pocatello, Ida

10. NAME OF FATHER Edward Amundsen

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Ruth C. Hall

13. BIRTHPLACE OF MOTHER (State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Amundsen
(Address) Pocatello, Ida

15. Filed Sept 17 1924
Local Registrar Ph...

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 17 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-17 1924 to 9-17 1924, that I last saw h. alive on Stillborn 1924, and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:
Stillborn

(Duration) yrs. mos. ds.
Contributory (Secondary) Hydrocephalus
(Duration) yrs. mos. ds.
(Signed) W. D.
9/17 1924 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Mt View Cem Pocatello Sept 17 1924

20. UNDERTAKER ADDRESS
McHan Undert Co. Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

266-245-003-269
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S
125674

County of Bannock
City of Payson

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 83 State File No. _____

Hospital _____ Primary Registration District No. 2160 Local Registrar's No. 55

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? _____ and { Number in order of birth _____ } Legitimate? Yes Date of birth Sept-15-1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Neosporol

Number of child of this mother, including present birth 12 Number of child of this mother now living, including present birth 11

FATHER
FULL NAME George Bowman
RESIDENCE Payson, Idaho
COLOR White AGE AT LAST BIRTHDAY 48
(Years)
BIRTHPLACE Richmond, Va
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Emma Jonsson
RESIDENCE Payson, Idaho
COLOR White AGE AT LAST BIRTHDAY 41
(Years)
BIRTHPLACE Richmond, Va
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at 6 40 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

W. H. Backstrom, M.D.
Physician
(Physician or midwife)

Address

Payson, Idaho

Filed

Oct-10-1924 Orary C. Coffin

Registrar.

Registrar.

...the child to the ...

1. The first of these is the fact that the
 2.

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the said Court at the City of New York, this 14th day of June, 1964.

OFFICE OF THE ATTORNEY GENERAL

4-20-68

14-00000

AGE AT LAST BIRTHDAY

SECRET

RENTAL

[illegible]

to have in (do) borrow of (T)

10 230

SECRET

Primary: _____ Hospital: _____

NOTICE

10-10-68

100-443887-100

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of Jarvis

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 83Primary Registration District No. 2160

No. _____ St. _____

File No. 47200Registered No. 9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

Sept - 15 - 1924
(Month) (Day) (Year)

7. AGE

Yrs. _____ Mos. _____ ds. _____

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)None

9. BIRTHPLACE

(State or Country)

Jarvis Idaho

10. NAME OF FATHER

George Bowman

11. BIRTHPLACE OF FATHER

(State or Country)

Richmond, Utah

12. MAIDEN NAME OF MOTHER

Emma Sorenson

13. BIRTHPLACE OF MOTHER

(State or Country)

Richmond, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Bowman

(Address)

Jarvis Idaho

15.

Filed Oct. 10 1924 Mary C. Coffey
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept - 15 - 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____.

that I last saw him _____ alive on _____ 19____.

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory Nephritis in Mother
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) B. J. Lortz M. D.(Address) Jarvis Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

_____ 19____

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

236-127003-996
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

125677

County of Pannak

City of Downey

No. R.D.

St. Registration District No. 83 State File No. 58

Hospital Primary Registration District No. 299 Local Registrar's No. 58

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? } and { Number in order of birth 1st Legiti- mate? Yes Date of birth Sept-27-1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 12 Number of child of this mother now living, including present birth 7

FATHER
FULL NAME Horace Bloxham

RESIDENCE Downey, Idaho

COLOR white AGE AT LAST BIRTHDAY 40
(Years)

BIRTHPLACE Downey, Idaho

OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Catherine Cross

RESIDENCE Downey, Idaho

COLOR white AGE AT LAST BIRTHDAY 39
(Years)

BIRTHPLACE Drifton, Utah

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 9 30 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
, 192

(Signature) [Signature]
Physician
(Physician or midwife)

Address Downey, Idaho

Filed Oct. 10 1924 Onary C. Coffin
Registrar.

STATE OF IDAHO
 DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. 1234 Registration District No. 1 State of Idaho
 Hospital St. Luke's Hospital

FULL NAME OF CHILD John Doe
 (Corrected) John Doe (Male) (Date of Birth) Jan 1 1900
 Sex Male Age 1 of 1 of 1
 (Date of Birth) Jan 1 1900 (Month) Jan (Day) 1 (Year) 1900

Place of Birth Idaho (County) Blaine
 Residence Idaho (County) Blaine
 Color White Age at Birth 1 (Years) 1
 Birthplace Idaho (County) Blaine
 Occupation None

Signature of Attending Physician or Midwife Dr. J. H. Smith
 Date Jan 1 1900

Address Idaho
 (Signature) Dr. J. H. Smith
 (Physician or Midwife)

THIS CERTIFICATE IS A PUBLIC RECORD AND IS NOT TO BE DESTROYED OR ALTERED IN ANY MANNER.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
OCT 12 1924
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **47198**
Registered No. **11**

1. PLACE OF DEATH
County of **Bannock** Registration District No. **8-8**
City of **Dawnay** Registration District No. **2160**
St. (No.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WID-OWED OR DIVORCED **single**
(Write the word.)

6. DATE OF BIRTH **Sept - 27 - 1924**
(Month) (Day) (Year)

7. AGE **2** Yrs. **10** Mos. **10** ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION **none**
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE **Dawnay, Idaho**
(State or Country)

10. NAME OF FATHER **Horace Bloxham**

11. BIRTHPLACE OF FATHER **Dawnay, Idaho**
(State or Country)

12. MAIDEN NAME OF MOTHER **Catharin Drom**

13. BIRTHPLACE OF MOTHER **Drafton, Utah**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Horace Bloxham**
(Address) **Dawnay, Idaho**

15. Filed **Oct 10 1924** **Mary E. Coffin**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Sept - 27 - 1924**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **19** to **19** that I last saw h. alive on **19** and that death occurred on the date stated above, at **M.**
The CAUSE OF DEATH* was as follows:

Asphyxia Pulmonalis

(Duration) **?** Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **H. H. H. H. H.** M. D.

(Address) **Dawnay, Idaho**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL **19**

20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name or gin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

236-127.003-996
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Barnack DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
City of Dawney CERTIFICATE OF BIRTH
No. _____ St. _____ Registration District No. 83 State File No. 125678
Hospital _____ Primary Registration District No. 8160 Local Registrar's No. 5-9
FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin <u>Triplet</u> } and { Number in order of birth <u>2^a</u>	Legitimate? <u>Yes</u>	Date of birth <u>Sept - 27 - 1924</u>
	(To be answered only in event of plural births)		(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 3

FULL NAME *Horace Bloham* FATHER _____
RESIDENCE *Lawney, Idaho*
COLOR *White* AGE AT LAST BIRTHDAY *40*
(Years)
BIRTHPLACE *Lawney, Idaho*
OCCUPATION *Fanner*

FULL MAIDEN NAME *Patricia Leon* MOTHER _____

RESIDENCE *Lawray, Asho.*

COLOR *white* AGE AT LAST BIRTHDAY *39* (Years)

BIRTHPLACE *Asho*

OCCUPATION *Housewife*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at _____ on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Fileć

Registrar.

Registrar.

There were no law enforcement officers present at the time of the shooting. The only person who was present was the victim, who was shot in the back of the head. The victim was found lying on the ground, and the shooter fled the scene. The victim was taken to the hospital, but died shortly after arriving. The police are currently looking for the shooter, and have issued a warrant for his arrest.

to build and develop a new village around I
Landing area and the sea

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE:

OCUPATION

274

1994

920405

FATHER

1104

MOTHER

Number of child in this mother, including present birth

Number of child of this mother now living, including present birth

There has been no other information received.

(edit: saying to have it also be removed)

10 204
B1143

Exhibit 1
1-25-2001

121 (11/11)

(Certificate of no value will not fill name of child)

Introduction

Primary Registration District No.

10-11-62

to 210

Count of

RECEIVED
BUREAU OF
COMMUNICATIONS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of BannockCity of Dawney

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

Registration District No. 83Primary Registration District No. 2160(City or Town) Dawney St.)File No. 47199Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDSingle
(Write the word.)

6. DATE OF BIRTH

Sept - 27 - 1924
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Dawney, Idaho

10. NAME OF FATHER

Horace Bloxham

11. BIRTHPLACE OF FATHER

(State or Country)

Dawney, Idaho

12. MAIDEN NAME OF MOTHER

Cathleen Dean

13. BIRTHPLACE OF MOTHER

(State or Country)

Drifton, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Horace Bloxham
Dawney, Idaho

15.

Filed Oct - 10 - 1924 Mary C. Coffin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept - 27 - 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____, to 19____.

that I last saw him alive on 19____.

and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Asphyxia pallida

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. J. Bachman M. D.(Address) Dawney, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19____

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each in order of birth stated.

269-215-886 533
PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Bingham

City of Blackfoot

NOV 8 1924

CERTIFICATE OF BIRTH 125773

No. 121

St. Registration District No. 121

State File No. 287

Hospital Primary Registration District No. 2194

Local Registrar's No. 287

FULL NAME OF CHILD Frances Sorenson

(Certificate of no value without full name of child)

Sex of Child Female

Twin
Triplet
or other?
(To be answered only in event of plural births)

and

Number
in order
of birth

Legiti-
mate?

Date of
birth Oct 15 1924

(Month) (Day) (Year)

What bactericidal solution was used in eyes? —

Number of child of this mother, including present birth 10

Number of child of this mother now living, including present birth 6

FATHER

FULL
MAIDEN
NAME

MOTHER

RESIDENCE Blackfoot P.O. Box

RESIDENCE Do

COLOR White

AGE AT LAST
BIRTHDAY 46
(Years)

COLOR White

AGE AT LAST
BIRTHDAY 39
(Years)

BIRTHPLACE Idaho

BIRTHPLACE Utah

OCCUPATION Farmer

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 10 a M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) W. E. Patie MD

(Physician or midwife)

Address Blackfoot Idaho

Filed Oct 15 1924

Registrar.

Registrar.

2

CERTIFICATE OF BIRTH

City of _____ State of _____
 Hospital _____
 No. _____

Full Name of Child _____
 Date of Birth _____
 (Month) _____ (Day) _____
 Sex _____
 Weight _____
 Length _____

Signature of Mother _____
 Signature of Father _____
 Name of Mother _____
 Name of Father _____
 Address _____

Color _____
 Birth Date _____
 Occupation _____
 Birth Place _____
 Age at Birth _____
 Cause of Death _____
 Residence _____

CERTIFICATE OF A BORN PHYSICIAN
 I hereby certify that I attended the birth of this child, who was _____
 on the date above stated.
 When there was no attending physician or midwife, then the father, mother, etc. should make the return. A child is one who is born alive, shows other evidence of life at birth, and comes forth from a spontaneous process.
 Signed _____
 Address _____
 Date _____

THIS IS TO CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN AT THE PLACE AND DATE HEREIN SET FORTH AND THAT THE SIGNATURE OF THE BORN PHYSICIAN IS A TRUE AND CORRECT STATEMENT OF THE FACTS HEREIN SET FORTH.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Bingham*City of *Blackfoot*Registration District No. *121*Primary Registration District No. *2194*

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Florence Sorenson*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *47255*Registered No. *132*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Oct 15 1924
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Bingham Co Idaho

10. NAME OF FATHER

Lawrence Oreg Sorenson

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Effie Ellis

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*L. G. Sorenson
Blackfoot P.O. Box 1922*

15.

Filed

*Oct 15 1924 Mrs Walter E. Sorenson
Local Registrar*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 15 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Oct 15 1924 to Oct 15 1924*that I last saw her *alive* *read* *19*and that death occurred on the date stated above, at *10* M.

The CAUSE OF DEATH* was as follows:

*Stillborn
Pregnancy 7 mo*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)*Overwork*

(Duration) yrs. mos. ds.

(Signed)

W. E. Sorenson M. D.

19.

(Address)

Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Cor. Nat'l Burial Ground Oct 15 1924

20. UNDERTAKER

ADDRESS

L. G. Sorenson B. Route

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

453-114-010-414
PLACE OF BIRTH

RECEIVED
OCT 15 1924

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of Bonneville

City of Idaho Falls

No. 120-1st St.

Registration District No. 73

State File No. 2128

CERTIFICATE OF BIRTH 125820

Hospital

Primary Registration District No. 2128

Local Registrar's No. 279

FULL NAME OF CHILD Stelborn Deluka

(Certificate of no value without full name of child)

Sex of Child

Male

Twin
Triplet
or other?
(To be answered only in event of plural births)

and { Number
in order
of birth

Legiti-
mate? Yes

Date of
birth Aug. 14

(Month) (Day)

1924
(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1

Number of child of this mother now living, including present birth 0

FATHER
FULL
NAME

Dominick Deluka

RESIDENCE

Idaho Falls, Idaho

COLOR

White

AGE AT LAST
BIRTHDAY 40

(Years)

BIRTHPLACE

Italy

OCCUPATION

Railroad employee

MOTHER
FULL
MAIDEN
NAME

Ruphona Mawie

RESIDENCE

Idaho Falls, Idaho

COLOR

White

AGE AT LAST
BIRTHDAY 34

(Years)

BIRTHPLACE

Italy

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive (Stillborn) at 7:45 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address Idaho Falls, Idaho

Filed Aug 20 1924

Registrar.

Registrar.

Experiments

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

294-211-200-449
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonniwell
City of Idaho Falls
OCT 10 1924
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

No. _____ St. Registration District No. _____ State File No. _____
Hospital Spencer Primary Registration District No. 21st Local Registrar's No. 31st
FULL NAME OF CHILD William

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ and { Number in order of birth _____ } Legitimate? Yes Date of birth Sept-11 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Boric acid

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME	<u>John Augustus Kimball</u>	FULL MAIDEN NAME	<u>Maud Murray</u>
RESIDENCE	<u>Idaho Falls</u>	RESIDENCE	<u>Idaho Falls</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>37</u> (Years)	AGE AT LAST BIRTHDAY	<u>36</u> (Years)
BIRTHPLACE	<u>Endington Mich</u>	BIRTHPLACE	<u>Endington Mich</u>
OCCUPATION	<u>Dentist</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 3:15 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) W. J. Kimball

(Physician or midwife)

Address Idaho Falls

Filed Oct 23 1924 W. J. Kimball

Registrar.

Registrar.

[illegible]

PLACE OF BIRTH

OFFICE OF THE
ATTORNEY GENERAL
STATE OF TEXAS

EX-100

Primary Registration District No. _____ Registrar's No. _____

UNITED STATES DEPARTMENT OF JUSTICE

10 292
6000

1941
Growth to 10
as of 07)

Index

44-38861-100

did not have sufficient information to make a decision on whether to issue a subpoena.

RENTON

100-443887-100

CONFIDENTIAL

HOJCA

YAGINTSIN

2015 JAN 12

COPIATION

MOITAGUS-100

• THE NO PHYSICIAN OR MIDWIFE.

SECRET

1911-12

... ..

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

235-127-014-542

County of

City of

No. 1420 Arthur St.

St.

Registration District No.

3

State File No.

Hospital

Primary Registration District No.

1025

Local Registrar's No.

153

FULL NAME OF CHILD

Gardner Stewart

(Certificate of no value without full name of child)

Sex of Child

M.

Twins
Triplet
or other?

8.

and

Number
in order
of birth

1

Legiti-
mate?

yes

Date of
birth

10/27

1924

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

none

Number of child of this mother, including present birth

1

Number of child of this mother now living, including present birth

0

FULL
NAME

FATHER

George M. Stewart

RESIDENCE

Caldwell Idaho

COLOR

W.

AGE AT LAST
BIRTHDAY

25

(Years)

BIRTHPLACE

Indian Valley Idaho

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Willie Trusty

RESIDENCE

Caldwell Idaho

COLOR

W.

AGE AT LAST
BIRTHDAY

21

(Years)

BIRTHPLACE

St. Joseph Oregon

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ^{Born alive} Stillborn at 4:30 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 1924

(Signature)

J. L. M. D.

(Physician or midwife)

Address

Caldwell Idaho

Filed

Oct. 31 - 1924 John L. Meyer

Registrar.

Registrar.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

125880

(Certificate of no value for name of child)

(Date)

NAME
RESIDENCE

BIRTHDAY

ATTENDING PHYSICIAN

OCCUPATION

on the date of
When there was
to identify them
also, should make
call is one that
shows other
give names added from

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth (CITY Caldwell FILE NO. 125980
(ST. Idaho DATE OF BIRTH Oct 27 1924
(COUNTY Canyon SEX OF CHILD Male
FATHER Geo M Steward MOTHER Milly Musty
(MAIDEN NAME)

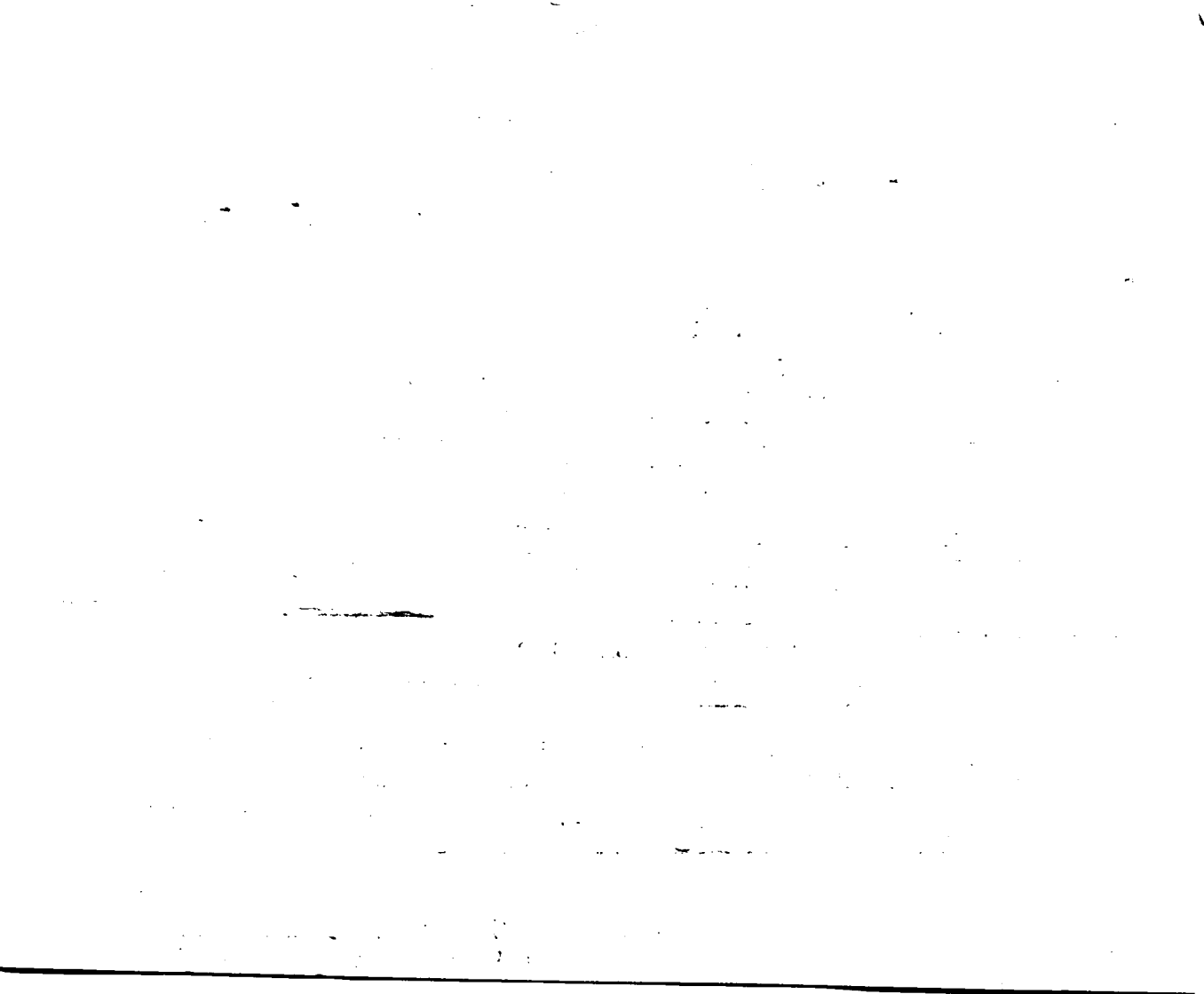
I HEREBY CERTIFY that the child herein described has been named:

Gardner Steward

Mrs Geo M Steward

Signature of Father or Mother.

RECEIVED



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of CanyonCity of Caldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Steward City

(No.)

St.)

Registration District No.

Primary Registration District No. 1005

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No.

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Single

(Write the word)

6. DATE OF BIRTH

Oct 27 1924
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF

Father

George Steward

11. BIRTHPLACE

OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME

OF MOTHER

Millie Musty

13. BIRTHPLACE

OF MOTHER

(State or Country)

Ore.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John L. Meyer(Address) 1420 Arthur City

15.

Filed Oct. 28 - 1924 John L. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 27 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19... to 19...
that I last saw him alive on 19...
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still born -

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. L. Meyer M. D.

1924-1924 (Address) Caldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

10-28 1924

20. UNDERTAKER

Paul L Case

ADDRESS

Caldwell Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

253-102-016-359
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

125975

County of Cassia

City of Burley

No. 58

Registration District No. 117

State File No.

Hospital

Primary Registration District No. 2196

Local Registrar's No. 2949

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child)

Sex of Child Male

Twin
Triplet
or other?
(To be answered only in event of plural births)

Number in order of birth

Legitimate? Yes

Date of birth Sept. 2, 1924
(Month) (Day) (Year)

What bactericidal solution was used in eyes?

10% Neosilver

Number of child of this mother, including present birth 5

Number of child of this mother now living, including present birth 4

FULL
NAME

FATHER

Raymond Delbert Kelley

RESIDENCE

Burley Idaho

COLOR White

AGE AT LAST
BIRTHDAY 50
(Years)

BIRTHPLACE

Payson Utah

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Jessie Adelia Terry

RESIDENCE

Burley Idaho

COLOR White

AGE AT LAST
BIRTHDAY 38
(Years)

BIRTHPLACE

Fairview Utah

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 2:00 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

D. D. Rich

Physician
(Physician or midwife)

Address

Burley, Ida

Filed 10-4

1924

Dr. J. C. Patterson

Registrar.

R. var.

CERTIFICATE OF DEATH

47324

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Cassia
City of BurleyRegistration District No. 117
Primary Registration District No. 2196
(No. _____ St.)

File No. _____

Registered No. 736

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Kelly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

MaleWhiteSingle
(Write the word)

6. DATE OF BIRTH

Sept.
(Month)2
(Day)1924
(Year)

7. AGE

Stillborn

Yrs. _____ Mos. _____ ds. _____

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Burley - Idaho

10. NAME OF FATHER

Raymond Helbert Kelly

11. BIRTHPLACE OF FATHER

(State or Country)

Payson - Utah

12. MAIDEN NAME OF MOTHER

Jessie Adeline Perry

13. BIRTHPLACE OF MOTHER

(State or Country)

Payson - Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. H. J. Rich, M.D.

(Address)

Burley, Idaho

15.

Filed 10 - 4 1924 H. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept
(Month)2
(Day)1924
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

at birth 10 to Sept 2 1924that I last saw him alive on 19and that death occurred on the date stated above, at 2:15 P. M.The CAUSE OF DEATH* was as follows: - Stillbirthcaused by extreme polyhydramnios - (over + gallons of amniotic fluid)

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory Severe hemorrhage of placenta
(Secondary)Labor apparently brought on & ft
(Duration) _____ yrs. _____ mos. _____ ds.pressure of water Dr. H. J. Rich, M. D.
(Signed)9-2-1924 (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

BurleySept 2 1924

20. UNDERTAKER

None

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *22 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probable* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

284-222-021-815

County of Franklin

City of Preston

No. St. Registration District No. 24 State File No.

Hospital Primary Registration District No. 211 Local Registrar's No. 254

FULL NAME OF CHILD No Name (Dead)

(Certificate of no value without full name of child)

Sex of Child	Female	Twin Triplet or other?		and	Number in order of birth	Legitimate?	Yes	Date of birth	October 22 1924
									(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 16 Number of child of this mother now living, including present birth 8

FULL NAME FATHER

William A. Shuldberg

RESIDENCE

Preston, Idaho R.F.D. #2

COLOR

White

AGE AT LAST BIRTHDAY

(Years)

BIRTHPLACE

Sweden

OCCUPATION

Farming

FULL MAIDEN NAME

MOTHER Sarah J. Hansen

RESIDENCE

Preston, Idaho R.F.D. #2

COLOR

White

AGE AT LAST BIRTHDAY

45 (Years)

BIRTHPLACE

Utah

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 8:30 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Physician

(Physician or midwife)

Address

Preston, Idaho

Filed

N. H. 1924

Registrar.

Registrar.



SECRET

with a 100% success rate.

127. *Thymus praecox* L. = *Thymus serpyllifolius* L. = *Thymus* sp.

1990

1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.

071229J

1997-1998

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho 1922

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY Preston FILE NO. 126027
(ST. _____
(COUNTY Franklin DATE OF BIRTH October 22
SEX OF CHILD Female
FATHER William A. Shulberg MOTHER Sarah Jane Hansen
(MAIDEN NAME)

I HEREBY CERTIFY that the child herein described has been named:

The child was dead at birth, no name was given.
Sarah was the name that we had selected.

Sarah J. Shulberg.
Signature of Father or Mother.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of FranklinCity of Preston

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 24Primary Registration District No. 2119(No. 1)

St.)

2. FULL NAME Sabe Shuldborg,STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSState File No. 47503Local Registrar's No. 52

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single (write the word)

6. DATE OF BIRTH

October 22, 1924. 1
(Month) (Day) (Year)

7. AGE

Premature Birth.0 Yrs 0 Mos 0 ds

IF LESS than 1 day how many
..... hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Preston, Idaho.

10. NAME OF FATHER

William A. Shuldborg/

11. BIRTHPLACE OF FATHER

(State or Country) Sweden.

12. MAIDEN NAME OF MOTHER

Sarah J. Hansen.

13. BIRTHPLACE OF MOTHER

(State or Country) Hyde Park, Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm H. Shuldborg(Address) Preston Idaho

15.

Filed Nov. 21924

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 22, 1924. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-23 1924 to 10-23-24 1924,
that I last saw him alive on 19,
and that death occurred on the date stated above, at 2:30 AM.

The CAUSE OF DEATH* was as follows:

Skellon

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Shuldborg M. D.Oct. 22, 1924 (Address) Preston, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Winder CemeteryOctober 22, 1924.

Local Registrar

ADDRESS Preston, Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. H.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

862-117-022
PLACE OF BIRTH

443

RECEIVED

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S126039

County of Fremont

City of St. Anthony

No. _____ St. _____ Registration District No. 99 State File No. _____

Hospital _____ Primary Registration District No. 2177 Local Registrar's No. 277

FULL NAME OF CHILD (Stillborn) Hobbs

(To be answered only in event of plural births)

Sex of Child <u>M</u>	Twins Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>May 17</u> , 192 <u>4</u> (Month) (Day) (Year)
-----------------------	--	-------	--------------------------------	------------------------	--

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 3

FATHER FULL NAME <u>J. T. Hobbs</u>	MOTHER FULL MAIDEN NAME <u>Ethel Mullerney</u>
RESIDENCE <u>St. Anthony, Ida</u>	RESIDENCE <u>St. Anthony, Ida</u>
COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>47</u> (Years)	COLOR <u>W</u> AGE AT LAST BIRTHDAY <u>33</u> (Years)
BIRTHPLACE <u>Utah</u>	BIRTHPLACE <u>Iowa</u>
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 930 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) James J. Geary

(Physician or midwife)

Address St. Anthony, Idaho

Filed 10913 1924 W. W. Hamers

Registrar.

Registrar.

2

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of *Blaine*Registration District No. *2177*City of *St. Anthony*Primary Registration District No. *99*State File No. *46753*Local Registrar's No. *85*

If death occurs away from usual residence, give facts called for under special information.

(No. _____) (St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

A. Steelbourn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE & SINGLE, MARRIED, WIDOWED OR DIVORCED

*White**Child*

(Write the word)

6. DATE OF BIRTH

*Aug.**17**1924*

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1 day how many
hrs. or min.?

— Yrs. — Mos. — ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

St. Anthony Idaho

10. NAME OF Father

Jesse P. Hobbs

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Ethel Mullinax

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*Jesse P. Hobbs
St. Anthony Idaho*

15.

Filed

*Aug. 17*19*24**W. M. Hansen*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 17

(Month)

(Day)

19*24*
(Year)17. I HEREBY CERTIFY, That I attended deceased from
19*24* to *Aug 17* 19*24*that I last saw h. alive on 19*24*,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

*Calcified placenta
causing death
in situ*

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. M. Hansen
St. Anthony Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*St. Anthony Idaho**Aug. 17* 19*24*

20. UNDERTAKER

ADDRESS

None

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

868-203.028-365

Form V. S. No. 11-C-25m-7-21-19

OF BIRTH		STATE OF IDAHO BUREAU OF VITAL STATISTICS		S 126077	
County of <u>Rootenai</u>		RECEIVED BUREAU OF VITAL STATISTICS		1924	
City of <u>Cataldo</u>		BUREAU OF VITAL STATISTICS		1924	
No. _____ St. _____		Registration District No. <u>1051</u>		File No. _____	
Hospital _____		Primary Registration District No. <u>1051</u>		Registered No. <u>1110</u>	
FULL NAME OF CHILD <u>Stillborn child of Mrs. Robert E. Hoyle</u>					
Sex of Child <u>girl</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate? <u>yes</u>	Date of Birth <u>Oct. 3</u> 19 <u>24</u> (Month) (Day) (Year)
FATHER FULL NAME <u>Robert Emmett Hoyle</u>			MOTHER FULL MAIDEN NAME <u>Helen May Connell</u>		
RESIDENCE <u>Cataldo</u>			RESIDENCE <u>Cataldo</u>		
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)		COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>16</u> (Years)	
BIRTHPLACE <u>Hamburg, Iowa</u>			BIRTHPLACE <u>Cataldo, Ida</u>		
OCCUPATION <u>Railway section man</u>			OCCUPATION <u>Housewife</u>		
Number of child of this mother, including present birth <u>2</u>			Number of children of this mother now living, including present birth <u>one</u>		
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*					
I hereby certify that I attended the birth of this child, who was <u>Stillborn</u> at <u>4:30 A.M.</u> on the date above stated. (Born alive or stillborn)					
<div style="display: flex; justify-content: space-between;"> <div> <p>*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.</p> <p>Given names added from a supplemental report. _____ 19____</p> <p>Registrar _____</p> </div> <div> <p>(Signature) <u>Robert Emmett Hoyle</u> <u>Husband</u> (Physician or midwife)</p> <p>Address <u>Cataldo, Ida</u></p> <p>Filed <u>Nov 5</u> 19<u>24</u> <u>D. W. Brennan</u> Registrar</p> </div> </div>					



FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

47393

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai
City of CataldoRegistration District No. 30Primary Registration District No. 1051

(No. _____ St.)

File No. _____

Registered No. 1445

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn child of Mrs. Robt. E. Hoyle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH

Oct. 3 1924
(Month) (Day) (Year)

7. AGE

No Yrs. No Mos. No ds.IF LESS than 1 day
how many No hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Cataldo, Ida

10. NAME OF FATHER

Robert Emmett Hoyle

11. BIRTHPLACE OF FATHER

(State or Country) Hamburg, Iowa

12. MAIDEN NAME OF MOTHER

Helen May Connell

13. BIRTHPLACE OF MOTHER

(State or Country) Cataldo, Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Emmet Hoyle
(Address) Cataldo, Idaho15. Mr. S. J. DormanFiled Nov. 5, 1924 S. J. Dorman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 3 1924
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I ~~attended~~ did not attend191..... to 191.....
that I last saw h..... alive on 191.....
and that death occurred on the date stated above, at 4:30 A. M.

The CAUSE OF DEATH* was as follows:

Stillborn child mother reports.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) L. J. Stauffer M. D.Oct 3 1924 (Address) Rock Lake, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Cataldo, Ida

DATE OF BURIAL

Oct 3 1924

20. UNDERTAKER

none employed

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for
and the number of each, in order of birth stated.

219-103-629-515
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Latah
City of Moscow
No. RD. St. Registration District No. 61
Hospital Primary Registration District No. 2141
FULL NAME OF CHILD Baby Barker
(Certificate of no value without full name of child.)
Sex of Child Male Twin Triplet or other? and Number in order of birth 1 Legitimate? yes Date of birth Oct 3 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bacteriocidal solution was used in eyes?.....

Number of child of this mother, including present birth..... Number of child of this mother now living, including present birth.....

FATHER		MOTHER	
FULL NAME	<u>Jessie M. Barker</u>	FULL MAIDEN NAME	<u>Gladys Vandenberg</u>
RESIDENCE	<u>Moscow, Idaho</u>	RESIDENCE	<u>Moscow, Idaho</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>35</u> (Years)	AGE AT LAST BIRTHDAY	<u>27</u> (Years)
BIRTHPLACE	<u>Washington</u>	BIRTHPLACE	<u>Washington</u>
OCCUPATION	<u>Laborer</u>	OCCUPATION	<u>Housewife</u>

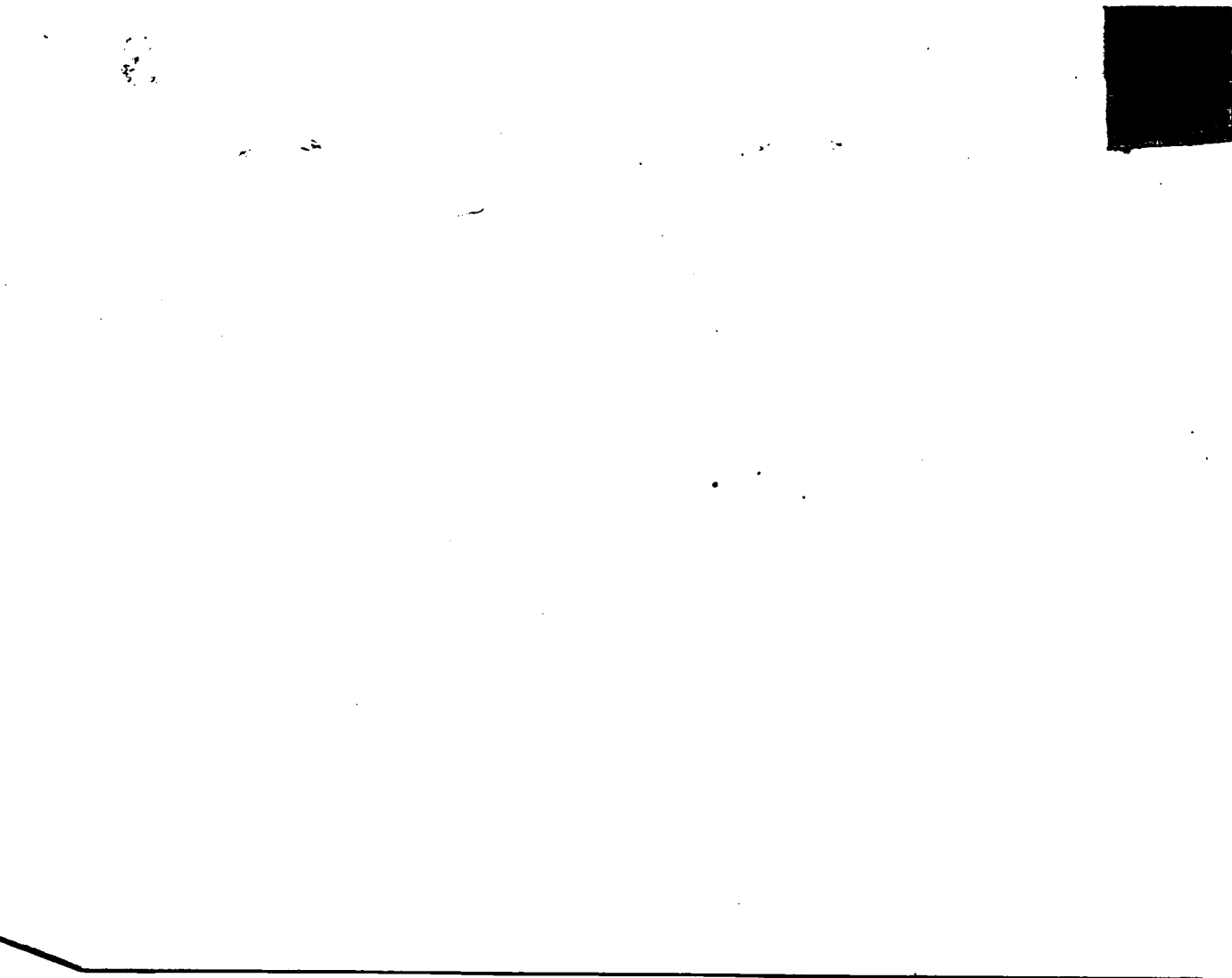
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was.....
on the date above stated. (Born alive or stillborn)

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Clifford O. Armstrong
Physician
(Physician or midwife)
Address Moscow, Idaho
Filed Dec 14 1924 N H Carithers
Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-1924 CERTIFICATE OF DEATH

1. PLACE OF DEATH. *Salah* Registration District No. *101*
County of *Salah* Primary Registration District No. *2141*
City of *P. R.* (No. _____) St. _____

State of Idaho
DEPARTMENT OF HEALTH
Bureau of Vital Statistics
No. *17401*
Registered No. *516*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Barker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Sept. 16 1924
(Month) (Day) (Year)

7. AGE

Still birth
yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Salah County

10. NAME OF FATHER

Jessie M. Barker

11. BIRTHPLACE OF FATHER

(State or Country)

Washington

12. MAIDEN NAME OF MOTHER

Grace M. Barker

13. BIRTHPLACE OF MOTHER

(State or Country)

Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Jessie Barker

(Address)

Phoenix, Idaho

15.

Filed

Nov 7

1924

McCarthers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 16 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Sept. 16 1924*, to *Sept 16 1924*, that I last saw ~~him~~ *her* alive on *191*, and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Stillborn baby about 2 or 3 months gestation
(Duration) yrs. mos. ds.
Contributory (Secondary) *Not known*
(Signed) *J. J. Cunningham* M. D.
19 (Address) *Phoenix, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

No undertaker

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

314-110-029-195 PLACE OF BIRTH

County of Latah

City of 6 miles East of Troy

No. 64 St. Registration District No. 64

Hospital Primary Registration District No. 2/114

FULL NAME OF CHILD Harold Emerson Campbell

RECEIVED
NOV 3 1924
BUREAU OF VITAL STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

126132

Sex of Child male Twin Triplet or other? and Number in order of birth 1 Legitimate? yes Date of birth Oct 10 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Lysol

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME Harry H. Campbell
RESIDENCE 6 miles East of Troy
COLOR White AGE AT LAST BIRTHDAY 34 (Years)
BIRTHPLACE Moscow Ida
OCCUPATION Rancher

MOTHER
FULL MAIDEN NAME Fern Lloyd Arnot
RESIDENCE 6 miles East of Troy
COLOR White AGE AT LAST BIRTHDAY 23 (Years)
BIRTHPLACE American Ridge, Idaho
OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 10:30 A M. on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.
October 31, 1924
Lucy M. Pickard
Registrar.

(Signature) L. F. Smith MD
(Physician or midwife)
Address Troy, Idaho
Filed Oct-31-1924 Lucy M. Pickard
Registrar.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho

NOV 10 1924

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY Troy FILE NO. 126132
ST. DATE OF BIRTH Oct 10.
COUNTY Latah SEX OF CHILD Male
FATHER W. H. Campbell MOTHER Fern L. Arnold
(MAIDEN NAME)

I HEREBY CERTIFY that the child herein described has been named:

Harold Emerson Campbell

Fern L. Campbell.
Signature of Father or Mother.

RECEIVED
26 1924

1. The first part of the document discusses the importance of maintaining accurate records of all transactions and the role of the accounting department in ensuring the integrity of the financial data. It emphasizes the need for transparency and accountability in all financial reporting.

2. The second part of the document outlines the various methods used to collect and analyze financial data, including the use of statistical models and the application of advanced data analysis techniques. It highlights the importance of using reliable data sources and the need for regular updates to the data.

3. The third part of the document discusses the challenges faced by the accounting department in maintaining accurate records and the importance of implementing robust internal controls to prevent errors and fraud. It also discusses the role of the accounting department in providing timely and accurate financial information to management and other stakeholders.

4. The fourth part of the document discusses the importance of maintaining accurate records of all transactions and the role of the accounting department in ensuring the integrity of the financial data. It emphasizes the need for transparency and accountability in all financial reporting.

5. The fifth part of the document outlines the various methods used to collect and analyze financial data, including the use of statistical models and the application of advanced data analysis techniques. It highlights the importance of using reliable data sources and the need for regular updates to the data.

6. The sixth part of the document discusses the challenges faced by the accounting department in maintaining accurate records and the importance of implementing robust internal controls to prevent errors and fraud. It also discusses the role of the accounting department in providing timely and accurate financial information to management and other stakeholders.

7. The seventh part of the document discusses the importance of maintaining accurate records of all transactions and the role of the accounting department in ensuring the integrity of the financial data. It emphasizes the need for transparency and accountability in all financial reporting.

8. The eighth part of the document outlines the various methods used to collect and analyze financial data, including the use of statistical models and the application of advanced data analysis techniques. It highlights the importance of using reliable data sources and the need for regular updates to the data.

9. The ninth part of the document discusses the challenges faced by the accounting department in maintaining accurate records and the importance of implementing robust internal controls to prevent errors and fraud. It also discusses the role of the accounting department in providing timely and accurate financial information to management and other stakeholders.

10. The tenth part of the document discusses the importance of maintaining accurate records of all transactions and the role of the accounting department in ensuring the integrity of the financial data. It emphasizes the need for transparency and accountability in all financial reporting.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah
City of 6 mi E of TroyRegistration District No. 64
Primary Registration District No. 2144
(No. St.)File No. 47408
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Campbell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male white Infant
(Write the word.)

6. DATE OF BIRTH.

Oct 10 1924
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

6 miles E. of Troy, Ida.

10. NAME OF FATHER

Harry H Campbell

11. BIRTHPLACE OF FATHER

(State or Country)

Moscow Ida

12. MAIDEN NAME OF MOTHER

Hern Lloyd Arnot

13. BIRTHPLACE OF MOTHER

(State or Country)

American Ridge, Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

L. F. Smith M.D.

(Address)

Troy, Ida

15.

Filed

Oct 31 1924 Lucy M. Pickard
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 10 1924
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 191 to Oct 10 1924that I last saw him alive on Oct 20 1924
and that death occurred on the date stated above, at about 1030 A.M.

The CAUSE OF DEATH* was as follows:

Difficult birth, separation of placenta premature.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Oct 10 1924 (Address) Troy, Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Buried - RidgeOct 11 1924none

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

141-111832-892
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

126144

County of Sevier
City of Canner
No. St. Registration District No. 41 State File No.
Hospital. Primary Registration District No. 246 Local Registrar's No.
FULL NAME OF CHILD not named Stillborn
(Certificate of no value without full name of child.)

Sex of Child <u>m.</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>2</u>	Legitimate? <u>Yes</u>	Date of birth <u>June 11, 1924</u> (Month) (Day) (Year)
------------------------	-----------------------------------	-----------------------------------	------------------------	--

What bactericidal solution was used in eyes? none
Number of child of this mother, including present birth. 8 Number of child of this mother now living, including present birth. 6

FATHER		MOTHER	
FULL NAME	<u>Harry Adams</u>	FULL MAIDEN NAME	<u>Nellie Jane Hibbs</u>
RESIDENCE	<u>Canner</u>	RESIDENCE	<u>Canner</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>53</u> (Years)	AGE AT LAST BIRTHDAY	<u>34</u> (Years)
BIRTHPLACE	<u>Penn.</u>	BIRTHPLACE	<u>Maine</u>
OCCUPATION	<u>Rancher</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive Stillborn at 4:45 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Chas F. Hume

(Physician or midwife)

Give names added from a supplemental report.

Address Salmon

Filed 10-18 1924 M. D. Davis

Regist.
Regist.

Regist.

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE STATE OF IDAHO ONLY. IT IS NOT VALID FOR ANY OTHER PURPOSES. IT IS NOT VALID FOR ANY OTHER PURPOSES. IT IS NOT VALID FOR ANY OTHER PURPOSES.

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

2

CERTIFICATE OF BIRTH

156144

County of _____
City of _____
No. _____
Hospital _____
Primary Registration Number _____
Local Registrar's Name _____

FULL NAME OF CHILD

(Certificate of no vote without full name of child)
First Name _____
Middle Name _____
Last Name _____
Sex _____
Date of Birth _____
Month _____
Day _____
Year _____
(To be answered only in case of still births)

If not hospitalized solution was used in case

Number of child of the mother, including present birth _____
Name of child, including present birth _____
MOTHER

FATHER _____
Name _____
Residence _____

Residence _____
Color _____
Age at last birthday _____
Birth date _____
Occupation _____

Birthplace _____
Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born on _____ at _____
on the date above stated.

*When there was no attending physician or midwife, the father, mother, or another person, if a resident of the county, may make this return. A affidavit shall be one that neither father nor mother shows other evidence of life after birth.

Give names added from a supplemental report

Signature _____
Date _____
Registrar _____
Notary _____

466-222-532-556
PLACE OF BIRTHSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Linn
 City of Shoshone
 No. _____ St. _____ Registration District No. 16 State File No. _____
 Hospital _____ Primary Registration District No. 2016 Local Registrar's No. 31
 FULL NAME OF CHILD Margaret Dealittle

NOV 12 1924 CERTIFICATE OF BIRTH

126163

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other?	and	Number in order of birth	Legiti- mate?	Date of birth	1924
	(To be answered only in event of plural births)			<u>yes</u>	<u>9-22</u> (Month) (Day)	<u>1924</u> (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 2

FATHER		MOTHER	
FULL NAME <u>Justin Dealittle</u>	FULL MAIDEN NAME <u>Mar Newman</u>	FULL NAME <u>Justin</u>	FULL MAIDEN NAME <u>Mar Newman</u>
RESIDENCE <u>Deerpick</u>	RESIDENCE <u>Deerpick</u>	RESIDENCE <u>Deerpick</u>	RESIDENCE <u>Deerpick</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>54</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>22</u> (Years)
BIRTHPLACE <u>Minn</u>	BIRTHPLACE <u>Mo</u>	BIRTHPLACE <u>Mo</u>	BIRTHPLACE <u>Mo</u>
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Wife</u>	OCCUPATION <u>Wife</u>	OCCUPATION <u>Wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {Born alive} at Shoshone on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

(Physician or midwife)

Give names added from a supplemental report.

Address

Filed

1924

Registrar.

Registrar.

THIS IS A PRELIMINARY REPORT AND NOT A FINAL REPORT. IT IS SUBJECT TO CORRECTION AND REVISION. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS NOT TO BE REPRODUCED OR TRANSMITTED IN ANY FORM OR BY ANY MEANS, ELECTRONIC OR MECHANICAL, INCLUDING PHOTOCOPYING, RECORDING, OR BY ANY INFORMATION STORAGE AND RETRIEVAL SYSTEM. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS NOT TO BE REPRODUCED OR TRANSMITTED IN ANY FORM OR BY ANY MEANS, ELECTRONIC OR MECHANICAL, INCLUDING PHOTOCOPYING, RECORDING, OR BY ANY INFORMATION STORAGE AND RETRIEVAL SYSTEM.

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

2

158168

No. _____ Registration District No. _____
Local Registration No. _____

FULL NAME OF CHILD

(Certificate of no child without full name of child)
Date of Birth (Month) (Day) (Year)
Sex of Child (Male) (Female)
Place of Birth (City) (County) (State)

If any institutional facilities were used in case

Name of Hospital or Institution (Including parent birth)
Name of Father
Name of Mother
Residence

Color
Age at Last Birthday (Years)
Occupation
Education

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was (Stillborn) (Born alive) on the date above stated.

(Signature)
When there is no attending physician or midwife, the father, mother, or other person, make the return. A stillbirth shall be one that neither shows nor shows other evidence of life after birth.

Give names added from a supplemental report

Address _____
Registered _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-12

CERTIFICATE OF DEATH

47432

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lincoln
City of ShoshoneRegistration District No. 76
Primary Registration District No. 1016
(No. _____ St.)

File No. _____

Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret Doolittle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single Born
(Write the word.)

6. DATE OF BIRTH

Oct 22 1924

(Month)

(Day)

(Year)

7. AGE

Still BornIF LESS than 1 day
how many _____ hrs. or
_____ min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...ado

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Justin Doolittle

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Mar Newman

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Justin Doolittle
Shoshone

15.

Filed

Oct 11 1924

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 22

(Month)

22

(Day)

1924

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 22 1924 to Sept 22 1924that I last saw him alive on Sept 22 1924and that death occurred on the date stated above, at 4:30 PM

The CAUSE OF DEATH* was as follows:

Born dead.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)I do not know

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

Address)

Justin Doolittle
Shoshone

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

1924

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH 485-207-032-466 RECEIVED
 COUNTY OF Shoshone NOV 16 1927 DEPARTMENT OF PUBLIC WELFARE
 CITY OF Shoshone BUREAU OF VITAL STATISTICS
 BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH **S 126165**

No. St. Registration District No. 16 State File No.

Hospital. Primary Registration District No. 1270 Local Registrar's No. 02

FULL NAME OF CHILD Mary Jo Myers

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>—</u>	Number in order of birth <u>—</u>	Legitimate? <u>Yes</u>	Date of birth <u>Oct 7</u> 192 <u>7</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 9 Number of child of this mother now living, including present birth 6

FATHER FULL NAME <u>Clarence Ernest Myers</u>	MOTHER FULL MAIDEN NAME <u>Laura Minnie Darnard</u>
RESIDENCE <u>Shoshone</u>	RESIDENCE <u>Shoshone</u>
COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>37</u> (Years)	COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>36</u> (Years)
BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Idaho</u>
OCCUPATION <u>Farmed</u>	OCCUPATION <u>wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 9. 2 M. on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) [Signature]
 (Physician or midwife)

Give names added from a supplemental report.

Address [Address]
 Filed Oct 17 1927 [Signature]
 Registrar.

1962

COMBIA

[illegible]

CERTIFICATE OF ATTENDING RHYTHMIC IN MOUNTAIN

NOTATION

BIMLHPLVCF

0050

TABLE 2
YOUTH

Figure 1

TRAILER
YACHTING

(27234)

3042-1234

J.117
J.118

REPLY:

1950

MOTHER

And, however, published, given - a person and

(The following information was obtained from the Bureau of Census.)

100-443888-100

4-11-68

— 1874 —

63004

Case 1

201
(1897)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth { CITY Shoshone FILE NO. 126165
 { ST. _____ DATE OF BIRTH May 6th '23
 { COUNTY Lincoln SEX OF CHILD Female

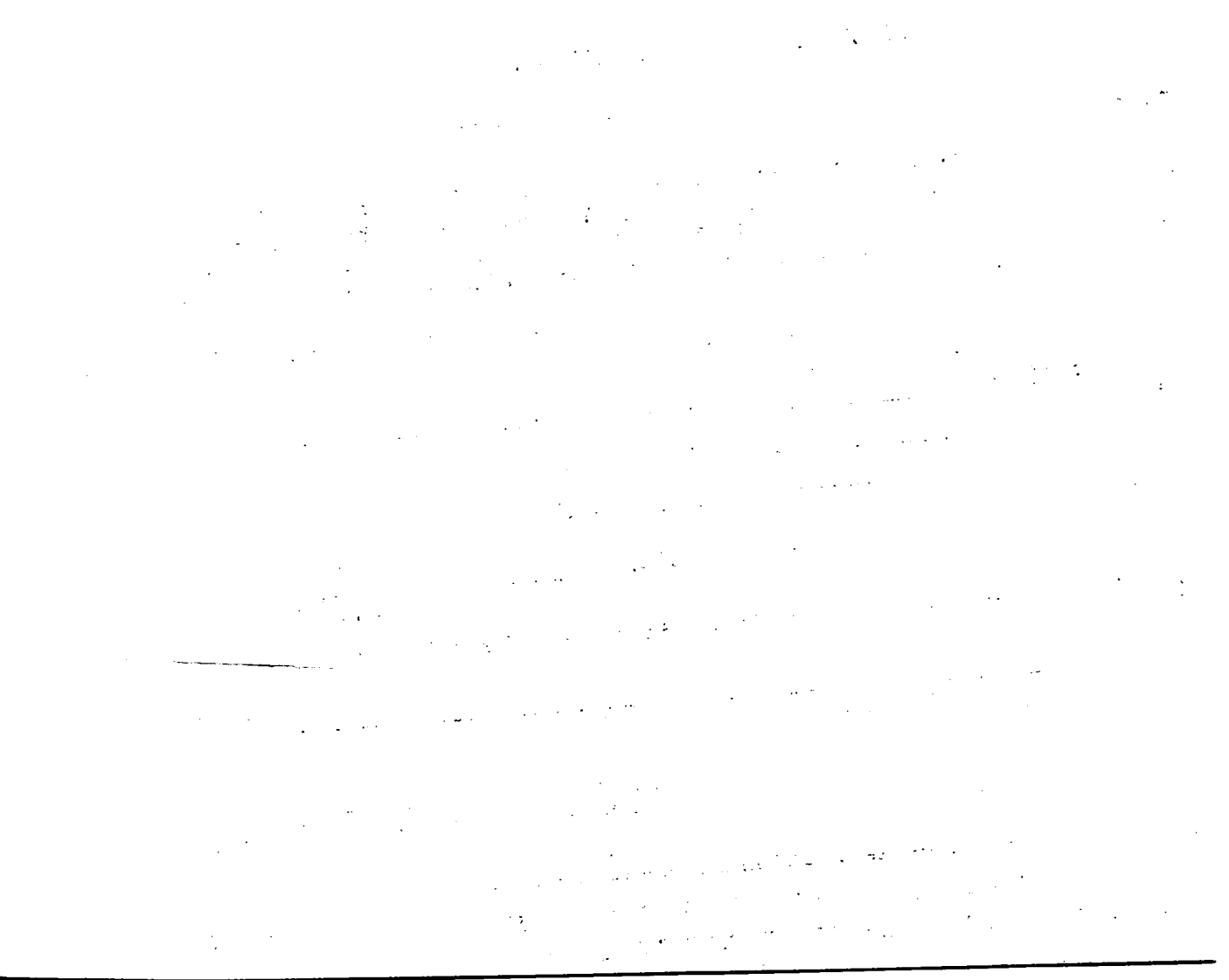
FATHER Claud Myers MOTHER Merilla Downard
(MAIDEN NAME)

I HEREBY CERTIFY that the child herein described has been named:

Mary Jo Myers

RECEIVED
NOV 19 1924

Mrs. Claud Myers
Signature of Father or Mother.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

263-204-03-63
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 126178

County of Modison City of Sugar City No. _____ St. _____ Registration District No. 100 State File No. _____

Hospital _____ Primary Registration District No. 2178 Local Registrar's No. 891

FULL NAME OF CHILD Stillborn
(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? Yes Date of birth Sept 4, 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 3

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Alejo Belensucha</u>	<u>Sugar City</u>	<u>Rosa Belensucha</u>	<u>Sugar City</u>
COLOR <u>Mex</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)	COLOR <u>Mex</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>Mexico</u>		BIRTHPLACE <u>Mexico</u>	
OCCUPATION <u>Labores</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

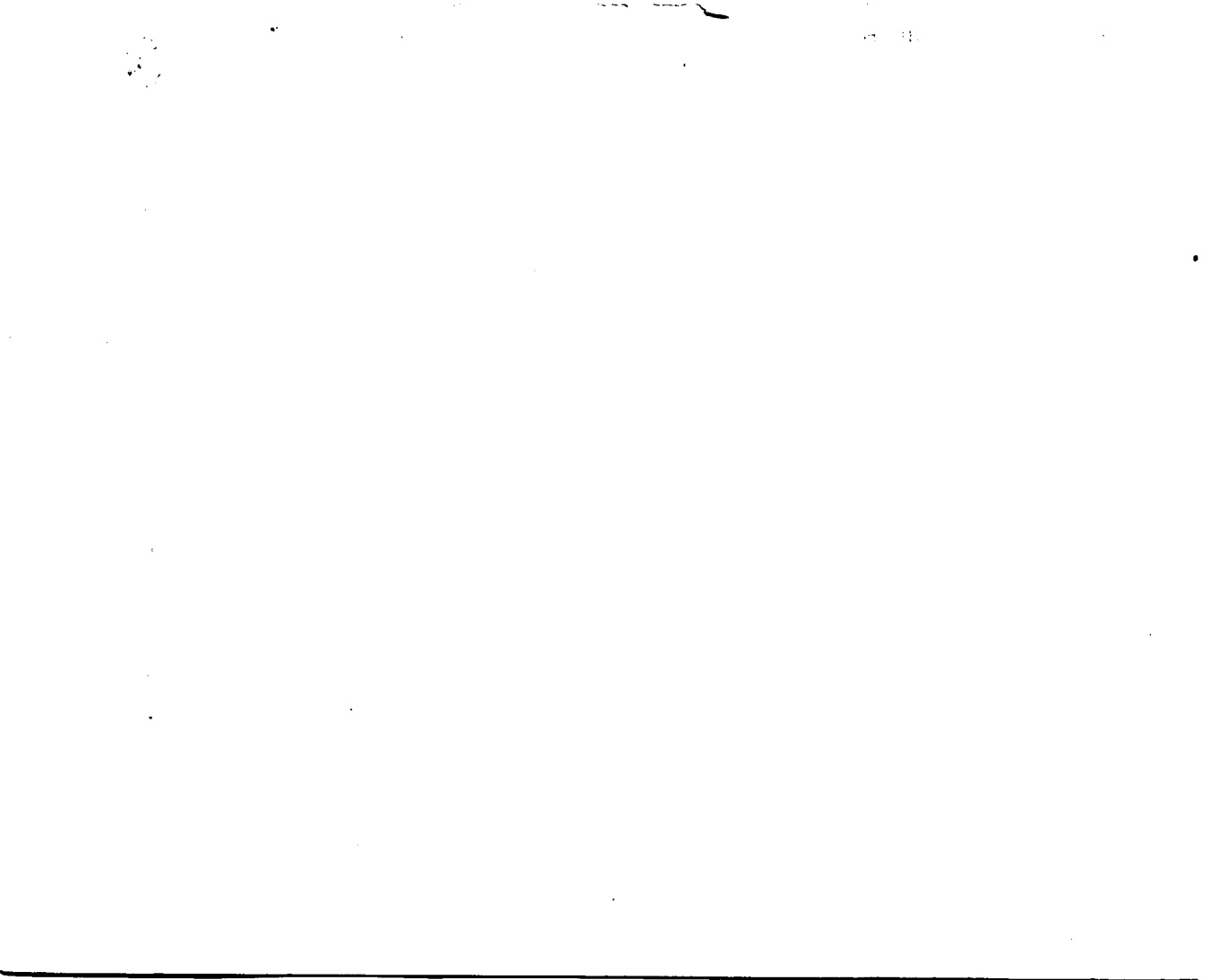
I hereby certify that I attended the birth of this child, who was Stillborn at 4:30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1924

(Signature) H. B. Rigby M.D.
(Physician or midwife)

Address _____
Filed 10/10 1924 J. J. J. J. J.
Registrar. Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

613-130-036-619
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Lincoln **RECEIVED**
City of Moscow **NOV 5 1924**
No. 26 **CERTIFICATE OF BIRTH** 126242
St. 26 Registration District No. 2069 State File No. 149
Hospital _____ Primary Registration District No. _____ Local Registrar's No. _____
FULL NAME OF CHILD Dead

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? Yes Date of birth 10-30 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? 1% Silver

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Wm. P. Waldron
RESIDENCE Evansford, Id.
COLOR White AGE AT LAST BIRTHDAY 35 (Years)
BIRTHPLACE Ida
OCCUPATION Farming

MOTHER
FULL MAIDEN NAME Clara Ware
RESIDENCE Evansford, Id.
COLOR White AGE AT LAST BIRTHDAY 33 (Years)
BIRTHPLACE Wis.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn ~~Born alive~~ at 6:45 PM on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1924

(Signature) J. M. Turner

(Physician or midwife)

Address Moscow

Filed 10-30 1924

Registrar.

Registrar.

2

PROBATION DEPARTMENT

1932

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth (CITY Gwenford FILE NO. 126242
(ST. _____ DATE OF BIRTH Oct 30, 1924
(COUNTY Oneida SEX OF CHILD Male
FATHER William Spencer MOTHER Amy S. Ware
Waldron (MAIDEN NAME)

I HEREBY CERTIFY that the child herein described has been named:

The child was dead born and it
was only a seven months baby.

Mrs. William S. Ware
Signature of Father or Mother.

RECEIVED
NOV 26 1924
BUREAU OF VITAL
STATISTICS



aldro

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

1. PLACE OF DEATH.

County of Oneida

City of Swanford

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.)

(No.)

(No.)

(No.)

(No.)

(No.)

(No.)

(No.)

(No.)

(No.)

(No.)

(No.)

(No.)

(No.)

(No.)

(No.)

(No.)

(No.)

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(No.)

(No.)

(No.)

(No.)

CERTIFICATE OF DEATH

17491

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No. 41

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

10

(Month)

30

(Day)

1924

(Year)

7. AGE

Still borne
yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Swanford Cldn

10. NAME OF FATHER

William Waldron

11. BIRTHPLACE OF FATHER

(State or Country)

Swanford Ida

12. MAIDEN NAME OF MOTHER

Amy Ware

13. BIRTHPLACE OF MOTHER

(State or Country)

Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Waldron

(Address)

Swanford - Cldn

15.

Filed

10/5/24

1924

J. M. Kees

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Still borne

191

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on

191

and that death occurred on the date stated above, at

M.

The CAUSE OF DEATH* was as follows:

Unknown (was a 7 mos. infant)

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

J. M. Kees M. D.

(Address)

Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days.

In the State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malad Cldn.

10-30-1924

20. UNDERTAKER

ADDRESS

J. Guy Kees

Malad Cldn.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

785 213-241-632
PLACE OF BIRTH

STATE OF **MISSISSIPPI**
DEPARTMENT OF **WELFARE**
BUREAU OF **VITAL STATISTICS**

S

County of **Teton** RECEIVED
City of **Teton** NOV 11 1924
No. **1924** Registration District No. **177** State File No. **126288**
Hospital **St. Luke's** Primary Registration District No. **2176** Local Registrar's No. **22**

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child **Male** Twin Triplet or other? **None** and Number in order of birth **1** Legitimate? **yes** Date of birth **Sept 13, 1924**
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? **None**

Number of child of this mother, including present birth **2** Number of child of this mother now living, including present birth **1**

FATHER
FULL NAME **Glen Russell Person**
RESIDENCE **Teton, Id.**
COLOR **White** AGE AT LAST BIRTHDAY **23** (Years)
BIRTHPLACE **Idaho**
OCCUPATION **Farmer**

MOTHER
FULL MAIDEN NAME **Leona Florence Olson**
RESIDENCE **Teton, Id.**
COLOR **White** AGE AT LAST BIRTHDAY **19** (Years)
BIRTHPLACE **Idaho**
OCCUPATION **Housewife**

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was **born** at **4 P.** on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) **Chas. West**
Physician
(Physician or midwife)

Give names added from a supplemental report.

Address **St. Luke's**
Filed **Oct 31-1924** **Martha Marker**
Registrar.

Registrar.

8



CONFIDENTIAL

2

1



1. PLACE OF DEATH

RECEIVED

Registration District No. 77

County of

NOV 6 1934

Primary Registration District No. 2176

City of

BUREAU OF

(No. 1114)

STATE

St.)

File No.

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Not named

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female

White

Single

6. DATE OF BIRTH

Sept. 13 1924

(Month)

(Day)

(Year)

7. AGE

Stillborn

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Infant.

9. BIRTHPLACE

(State or Country)

Teton, Idaho

10. NAME OF FATHER

Glen Russell Pearson

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Lorna Florence Olson

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Glen Russell Pearson

(Address)

Teton, Idaho

15.

Filed Oct 31 - 1934

Martha Marker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 13 1934

(Month)

(Day)

(Year)

17. HEREBY CERTIFY, That I attended deceased from

Sept 13 1934 to Sept 13 1934

that I last saw him

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn. Morivated with other when born.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Chas J. Martin M. D.

(Address)

Teton, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Teton, Idaho.

9-14-1934

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

639,227,092-453

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Twin Falls

City of Twin Falls

NOV 3
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. St. Registration District No. 37 State File No. 126358

Hospital C.O. General Primary-Registration District No. 1085 Local Registrar's No.

FULL NAME OF CHILD Frances Oliver

(Certificate of no value without full name of child)

Sex of Child female Twin Triplet or other? - and { Number in order of birth - } Legitimate? yes Date of birth Sept 27 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? -

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Claude P. Oliver</u>	<u>Filer Idaho</u>	<u>Marie Delaney</u>	<u>Filer Idaho</u>
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>29</u> (Years)
BIRTHPLACE <u>Kansas</u>		BIRTHPLACE <u>Ill.</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 11:15 P.m., M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Hal Bielu

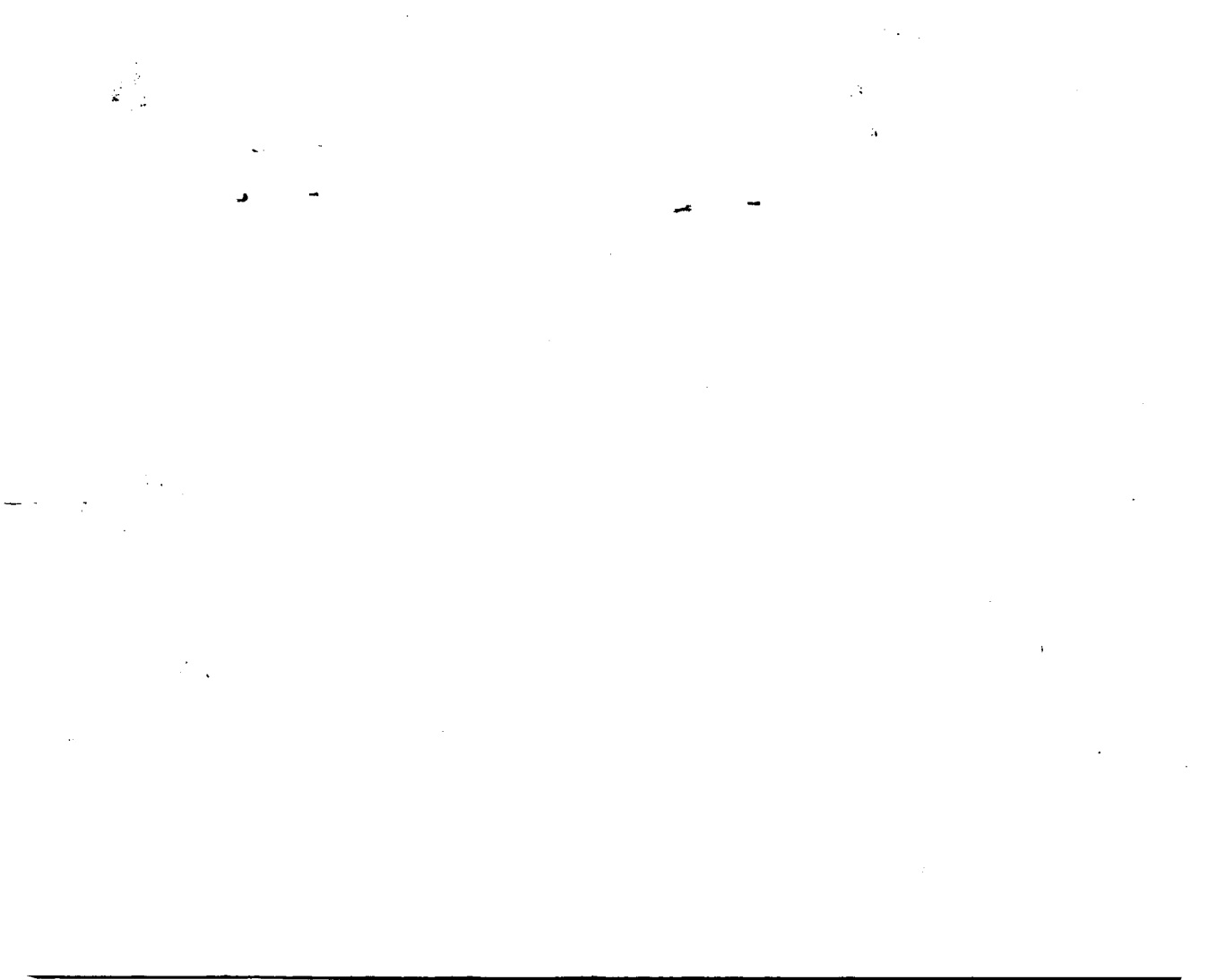
(Physician or midwife)

Address Twin Falls

Filed Nov. 1 1924

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Twin Falls*
City of *Twin Falls*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. *37*
Primary Registration District No. *1085*
St. *Gen. Hospital*

Frances Oliver

47534

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. _____

Local Registrar's No. *Cremated*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

(Write the word)

6. DATE OF BIRTH

Sept. 27 1924
(Month) (Day) (Year)

7. AGE

Yrs. _____ Mos. _____ ds. _____

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Cody, Idaho Co. Hospital

10. NAME OF FATHER

Claude P. Oliver

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Marie Delaney

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hal Bieler M.D.

(Address)

Twin Falls

15.

Filed

Nov. 1-24 19

John F. Coughlin

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 27 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *1924* to *1924*

that I last saw him alive on *Sept. 27* 1924, and that death occurred on the date stated above, at *Gen. Hospital*

The CAUSE OF DEATH* was as follows:

Still born

Contributory (Secondary)

(Signed)

Oct. 1 1924

(Address)

Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted if not at place of death? _____ Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Cremation

DATE OF BURIAL

Sept. 27 1924

20. UNDERTAKER

ADDRESS

Gen. Hospital Twin Falls, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

MAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
—in case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

369-104-120 544
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

126430

S

County of Ada

City of Boise

RECEIVED

DEC 4 1924

No. 1004 State File No. 2

Hospital St. Alphonsus Primary Registration District No. 1004 Local Registrar's No. 405

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>11 - 4 - 1924</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------	-----------------------------	---

What bactericidal solution was used in eyes? 1% Silver Nitrate Sol.

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER		MOTHER	
FULL NAME <u>Frank P. Corby</u>	FULL MAIDEN NAME <u>Evelyn A. Edmundson</u>		
RESIDENCE <u>430 So 10th St. Boise</u>	RESIDENCE <u>430 So 10th St. Boise</u>		
COLOR <u>White</u>	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)	AGE AT LAST BIRTHDAY <u>21</u> (Years)
BIRTHPLACE <u>Kansas</u>	BIRTHPLACE <u>Nebraska</u>		
OCCUPATION <u>Barber</u>	OCCUPATION <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 8 P.M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. T. N. Braxton
Physician
(Physician or midwife)

Give names added from a supplemental report.

Address Boise, Idaho
Filed Dec. 1 1924 R. H. Pratt
Registrar.

192

colman tried to rob me. i was 10-7-68 when all this happened

PLACE OF BIRTH

OHIO TO STATE

STATEMENT OF PUBLIC WORKS

PROBATE RE-LATIVELY NO MAINS

CERTIFICATE OF RIGHT

000000

No. _____
Registration District No. _____

No. _____
Primary Registration District No. _____

NOTICE TO THE PUBLIC

[illegible][illegible]

79973 mi head water collection (abandoned) and 11

did not have a right to be heard.

NAME	FULL	FATHER	MOTHER
1	MAIDEN		
2	MAIDEN		
3	MAIDEN		
4	MAIDEN		
5	MAIDEN		
6	MAIDEN		
7	MAIDEN		
8	MAIDEN		
9	MAIDEN		
10	MAIDEN		
11	MAIDEN		
12	MAIDEN		
13	MAIDEN		
14	MAIDEN		
15	MAIDEN		
16	MAIDEN		
17	MAIDEN		
18	MAIDEN		
19	MAIDEN		
20	MAIDEN		
21	MAIDEN		
22	MAIDEN		
23	MAIDEN		
24	MAIDEN		
25	MAIDEN		
26	MAIDEN		
27	MAIDEN		
28	MAIDEN		
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FORM NO. 10-67

CTOR

78A. TA 362.
YADN (HIB)

2010

AGE AT LAST
BIRTHDAY

30424117418

FOIA b 7(D)

OCUPATION

1101680000

CERTIFICATE OF ATTENDANCE OF PHYSICIAN OR MIDWIFE

on the date above stated. I hereby certify that:

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific information required.

1917]

实验五

425K

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
DEC 4 1924
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. 2
City of Boise Primary Registration District No. 1004
(No. St. Alphonsus Hospital)

File No. 47563
Registered No. 261

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Corby.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Nov 4 - 1924
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Frank Corby.

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Evelyn Edmondson

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Corby.

(Address)

15.

Filed Nov. 5 19 24

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 4 19 24
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4 19 24 to Nov 4 19 24

that I last saw him alive on Nov 4 19 24
and that death occurred on the date stated above, at 8:30 M.

The CAUSE OF DEATH* was as follows:

Congenital Deficiency of Head & Breech Presentation

(Duration) Yrs. mos. hrs. ds.
Contributory (Secondary) Difficult Delivery

(Duration) Yrs. mos. ds.
(Signed) J. W. Bratten M. D.

19. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Leam

Nov 5 19 24

20. UNDERTAKER

ADDRESS

Sumner & Co.

Boise Id

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

553-125-001-813
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

126443

County of Ada **RECEIVED**
City of Boise DEC 1924
No. 1401 No. 19th St. Registration District No. 2 File No. _____
Hospital _____ Primary Registration District No. 1007 Registered No. 287
FULL NAME OF CHILD Kelly Nelson
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? <u>—</u> and { Number in order of birth <u>—</u>	Legiti- mate? <u>yes</u>	Date of birth <u>Oct 25</u> 192 <u>4</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bacterioidal solution was used in eyes? none

Number of child of this mother, including present birth 2nd Number of child of this mother now living, including present birth 1

FATHER	MOTHER
FULL NAME <u>H. M. Nelson</u>	FULL MAIDEN NAME <u>Loris E. Haek</u>
RESIDENCE <u>1401 No. 19th St.</u>	RESIDENCE <u>1401 No. 19th St.</u>
COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>33</u> (Years)	COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>30</u> (Years)
BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Idaho</u>
OCCUPATION <u>Carpenter</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 10:00 P.M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. M. Taylor

17th St.
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address Boise, Idaho

Filed Nov. 13 1924 P. H. Pratt
Registrar.

2

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1000

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 2
 County of Ada Primary Registration District No. 1004
 City of Boise (State) Idaho (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Nelson

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 47172
 Registered No. 248

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

Oct. 25 - 1924
 (Month) (Day) (Year)

7. AGE

Still Born
 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Boise, Idaho

10. NAME OF FATHER

H. M. Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Iris. Flack

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wm. Gratz
Boise, Idaho

15.

Filed Oct. 27 1924 R. H. Pratt
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 25 - 1924
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 25 1924, to Oct. 25 1924
 that I last saw him alive on Still born 1924
 and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Death had occurred several weeks before birth - some disturbance of placental circulation
 (Duration) Yrs. mos. ds.

Contributory (Secondary)

No history of accident

(Duration) Yrs. mos. ds.

(Signed)

J. M. Taylor M. D.
10/25/24 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

Boise

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery

10/26/24

20. UNDERTAKER

ADDRESS

Wm. Gratz

Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

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STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

134-113-003-31K
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock
City of Pocatello
No. 657 No. 7th St. Registration District No. 28 State File No. 126465
Hospital St. Anthony's Hosp. Primary Registration District No. 2141 Local Registrar's No. 6470
FULL NAME OF CHILD St. Anthony's Hosp.

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? and { Number in order of birth } Legitimate? Yes Date of birth July 13 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Silver nitrate 1%

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 6

FATHER
FULL NAME Augustus Theodore Aldous
RESIDENCE 430 No. 7th Ave.
COLOR White AGE AT LAST BIRTHDAY 41 (Years)
BIRTHPLACE Pa
OCCUPATION Auto Mechanic

MOTHER
FULL MAIDEN NAME Margbell Maud Lambert
RESIDENCE 430 No. 7th Ave.
COLOR White AGE AT LAST BIRTHDAY 41 (Years)
BIRTHPLACE Lycoming County - Penn.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn { Born alive } at 12:45 Noon M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) AM Newton MD

(Physician or midwife)

Address Pocatello

Filed 1/11 1924
Registrar. Registrar.

2

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
STATE OF ILLINOIS
CERTIFICATE OF BIRTH

No. of Registration District No.

Primary Residence District No.

FULL NAME OF CHILD

(Continued on no. nine without any change of date)

Sex	Color	Weight	Length	Head	Birth	Time
Male	White	10 lbs.	19 in.	13 in.	11:30	11:30

Place of birth of mother

Place of birth of child

MOTHER

FULL NAME

RESIDENCE

COLOR

BIRTHPLACE

OCCUPATION

AGE AT LAST BIRTHDAY

COLOR

BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child who was born on

(Signature)

There were no attending physician or midwife then the child was born. A female child was born. A full term child of one last month gestation. No other evidence of the child's birth.

Attended

Witness

THIS IS A COPY OF THE ORIGINAL RECORD OF BIRTH AS KEPT IN THE OFFICE OF THE CLERK OF THE COUNTY OF COOK, ILLINOIS. IT IS NOT TO BE USED AS EVIDENCE IN ANY COURT OF LAW.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock Registration District No. 28
 City of Pocatello (No. St. Anthony Hospital)
 Primary Registration District No. 2161

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Aldous

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 46609Registered No. 4384

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH

July 13 1924
 (Month) (Day) (Year)

7. AGE

stillborn
 Yrs. Mos. ds.

IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country) Pocatello Idaho

10. NAME OF FATHER

A. I. Aldous

11. BIRTHPLACE OF FATHER

(State or Country) Downey Idaho

12. MAIDEN NAME OF MOTHER

Maybel Lambert

13. BIRTHPLACE OF MOTHER

(State or Country) Bannock

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. I. Aldous
 (Address) Pocatello

15. 7/14 1924
 Filed

[Signature]
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 13 1924
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
July 12 1924, to July 13 1924
 that I last saw him alive on 19
 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillbirth. Cause unknown.
Forten incidently had been dead about
7 to 10 days. Mother has had two
stillbirths (Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.
 (Signed) A. M. Newton M. D.
7/13 1924 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View Cem July 14 1924
 20. UNDERTAKER Shumacher & Hall ADDRESS Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

132-120003-75 RECEIVED
PLACE OF BIRTH NOV 17 1924
County of Bannock
City of Pocatello Idaho
No. _____ St. _____ Registration District No. 28 File No. 126569
Hospital _____ Primary Registration District No. 2141 Registered No. 1693
FULL NAME OF CHILD John Atkinson - Still birth
(Certificate of no value without full name of child.)
Sex of Child male Twin Trisist { and { Number yes Date of birth Oct 20 1924
or other? (To be answered only in event of plural births) Legiti- (Month) (Day) (Year)
mated?

What bactericidal solution was used in eyes? none still birth
Number of child of this mother, including present birth... 4 ... Number of children of this mother now living, including present birth... 3 ...
FULL NAME Phillip W Atkinson FATHER FULL MAIDEN NAME Hazel C Preese MOTHER
RESIDENCE Pocatello Idaho RESIDENCE Pocatello Idaho
COLOR white AGE AT LAST BIRTHDAY 38 COLOR white AGE AT LAST BIRTHDAY 26
(Years) (Years)
BIRTHPLACE Idaho BIRTHPLACE Idaho
OCCUPATION Gen. Laborer OCCUPATION H W

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was... Stillborn ... at... 4 w M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. F. Miller
Physician or midwife

Give names added from a supplemental report.

Address 1044 Box Pocatello Idaho

Filed 11/1 1924 Registrar.

RECORD IN THE BUREAU OF THE DISTRICT OF COLUMBIA WILL BE MAINTAINED WITH A VIEW TO THE
 RECORD IN THE BUREAU OF THE DISTRICT OF COLUMBIA WILL BE MAINTAINED WITH A VIEW TO THE
 RECORD IN THE BUREAU OF THE DISTRICT OF COLUMBIA WILL BE MAINTAINED WITH A VIEW TO THE

STATE OF MARYLAND
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

Registration District No. _____
 Hospital _____
 Primary Registration District No. _____
 Registered No. _____

FULL NAME OF CHILD

Sex of Child _____
 Date of Birth _____
 Time of Birth _____
 Place of Birth _____

What descriptive notation was used in case _____
 Number of child of this mother _____
 Number of child of this father _____

FATHER		MOTHER	
NAME	NAME	NAME	NAME
RESIDENCE	RESIDENCE	RESIDENCE	RESIDENCE
COLOR	COLOR	COLOR	COLOR
AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY	AGE AT LAST BIRTHDAY
BIRTHPLACE	BIRTHPLACE	BIRTHPLACE	BIRTHPLACE
OCCUPATION	OCCUPATION	OCCUPATION	OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
 (Signature) _____
 Address _____
 Date _____

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of San Juan
 City of Poestello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28
 Primary Registration District No. 2141
 (No. St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 47595
 Registered No. 4463

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

John Atkinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

male

White

Single
 (Write the word.)

6. DATE OF BIRTH

Oct 20

(Month)

(Day)

1924
 (Year)

7. AGE

Still birth
 Yrs. Mos. ds.

IF LESS than 1 day
 how many 0 hrs.
 or 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Poestello Idaho

10. NAME OF FATHER

Phillip Atkinson

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Hazel C. Bruce

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Father - Phillip Atkinson

(Address)

Poestello Idaho

15.

Filed

10/21 1924

J. H. Miller
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 20th

(Month)

(Day)

1924
 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1924 to Nov 20 1924

that I last saw him alive on Oct 20 1924

and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Stillbirth - Cause probable 7 and 8 months child.

(Duration) 0 Yrs. 0 mos. 0 ds.

Contributory
 (Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed)

J. H. Miller

M. D.

10/21/24 (Address) Poestello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Indian Idaho

DATE OF BURIAL

Oct 21 1924

20. UNDERTAKER

Phillip Atkinson

ADDRESS

Poestello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

319-0509-433
PLACE OF BIRTH

RECEIVED
DEC 6 1924

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bonner

City of Samuels

No. _____ St. _____

Registration District No. 76

File No. 126572

Hospital _____ Primary Registration District No. 2155

Registered No. _____

FULL NAME OF CHILD (Stillborn) Carmicheal
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u> }	Legitimate? <u>yes</u>	Date of birth <u>Nov 5</u> 192 <u>4</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What bactericidal solution was used in eyes? Silver nitrate

Number of child of this mother, including present birth 10 Number of child of this mother now living, including present birth 7

FATHER		MOTHER	
FULL NAME	<u>E. B. Carmicheal</u>	FULL MAIDEN NAME	<u>Sarah M McCabe</u>
RESIDENCE	<u>Samuels Ida</u>	RESIDENCE	<u>Samuels</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>43</u> (Years)	AGE AT LAST BIRTHDAY	<u>36</u> (Years)
BIRTHPLACE	<u>Centerville Maryland</u>	BIRTHPLACE	<u>Central City, Nebr.</u>
OCCUPATION	<u>Rancher</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at Samuels on the date above stated. 20 P M.
(Born alive or stillborn)

* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Floyd E. Wood
F. M. W.
(Physician or midwife)

Give names added from a supplemental report.

Address Sandpoint, Ida.

Filed Dec 4 1924 Viola Allen
Deputy Registrar.

Registrar.

2
DEPARTMENT OF HEALTH
MINISTRE OF STATISTICS

CERTIFICATE OF DEATH

File No.

Registration District No.

Age	Sex	Color	Religion

Number of children of this mother	
Living	Deceased

Occupation	Education

Cause of Death	
Signature of Physician	
Signature of Registrar	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
DEC 6 1924
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 47631

1. PLACE OF DEATH
County of Bonne Registration District No. 78
City of Samuel Primary Registration District No. 2153
(No. (Stillborn) St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Caricicheal

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word.)

16. DATE OF DEATH Nov-2-24
(Month) (Day) (Year)

6. DATE OF BIRTH Nov 5 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 19 19
that I last saw him Stillborn alive on 19 19 19
and that death occurred on the date stated above, at M.

7. AGE Stillborn IF LESS than 1 day
how many hrs.
Yrs. Mos. ds. or min. ?

The CAUSE OF DEATH* was as follows:
Circulation put off by
knock in with bilical cord

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

(Duration) Yrs. mos. ds.

9. BIRTHPLACE Samuels, Ida
(State or Country)

Contributory (Secondary)

10. NAME OF FATHER E. B. Carmicheal

(Duration) Yrs. mos. ds.

11. BIRTHPLACE OF FATHER Centerville, Maryland
(State or Country)

(Signed) W. H. W. W. W. M. D.

12. MAIDEN NAME OF MOTHER Sarah McCabe

(Address) Sandpoint, Ida

13. BIRTHPLACE OF MOTHER Central City, Nebr.
(State or Country)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. B. Carmicheal
(Address) Samuels, Ida

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

15. Filed Nov 6 1924 Viola Allen
Deputy Local Registrar

19. PLACE OF BURIAL OR REMOVAL Samuels, Ida DATE OF BURIAL Nov 6 1924

20. UNDERTAKER E. B. Carmicheal ADDRESS Samuels

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 22 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

395-122100-2
PLACE OF BIRTH - 415STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

126597

County of Bonner
City of Prineville

CERTIFICATE OF BIRTH

No. 54 Registration District No. 85 State File No. S
Hospital Primary Registration District No. 2185 Local Registrar's No. 365

FULL NAME OF CHILD

Clyde Arthur Lincoln
(Certificate of no value without full name of child)Sex of Child M Twin Triplet or other? and { Number in order of birth Legitimate? yes Date of birth Oct 21 1924
(To be answered only in event of plural births) (Month) (Day) (Year)What bactericidal solution was used in eyes? Number of child of this mother, including present birth 2Number of child of this mother now living, including present birth 1

FULL NAME

FATHER

Arthur Lincoln

FULL MAIDEN NAME

MOTHER

Lillian Manning

RESIDENCE

Prineville

RESIDENCE

Prineville

COLOR

W

AGE AT LAST BIRTHDAY

(Years)

COLOR

W.

AGE AT LAST BIRTHDAY

(Years)

BIRTHPLACE

Calif.

BIRTHPLACE

Idaho

OCCUPATION

Laborn

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at 3 P. M. on the date above stated.

(Signature)

G. P. Gatzoff

(Physician or midwife)

Address

Prineville

Filed

1924

Registrar.

Registrar.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 1924

STATE OF NEW YORK
DEPT. OF CORRECTIONS
BUREAU OF PRISON INDUSTRIES
CERTIFICATE OF RELEASE

all are state

24

10-11-68

CONFIDENTIAL: NO VALUE WITHOUT THIS MARKING

**Legal
Forum**

(adn: 1: 100)

20 1000
1000 1000

(1947) (1947)

2000

Number of calls in this folder was 100

NAME
MADON
RUBIN

4444
2222

SECRET

2010年10月10日

89-103

953-710

10-10-68

13-00000

NOTATION

14-00000

now only blind and to avoid not being able to see others, I

...the ... of ...
...the ... of ...
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...the ... of ...

20974A

(S) (U)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

47638

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bonner
City of Priest RiverRegistration District No. 86Primary Registration District No. 2185State File No. 4Local Registrar's No. 1266

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clyde Arthur Lincoln

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

Oct. 29 1924
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)At home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Arthur L. Lincoln

11. BIRTHPLACE OF FATHER

(State or Country)

California

12. MAIDEN NAME OF MOTHER

Lillaine Manning

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Arthur L. Lincoln
Priest River, Idaho

15.

Filed

Nov. 1 1924

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 29

(Month)

(Day)

29
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____ to _____ 19____,

that I last saw him alive on _____ 19____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Still BirthContributory
(Secondary)

(Duration) yrs. mos. ds.

(Duration) yrs. mos. ds.

(Signed)

19____

(Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Priest River CemeteryOct. 29 1924

20. UNDERTAKER

ADDRESS

R. E. Wesssa, Priest River

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

731-162010-369
PLACE OF BIRTH

County of Bonneville
City of Idaho Falls

No. Rt. # 6 St.

Hospital

FULL NAME OF CHILD

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED
DEC 11 1924
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. 73 State File No. 126687

Primary Registration District No. 21479 Local Registrar's No. 709

Stillborn Clark

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>Oct 12 1924</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 4

FATHER
FULL NAME Frank Clark
RESIDENCE Idaho Falls, Rt. # 6
COLOR White AGE AT LAST BIRTHDAY 63 (Years)
BIRTHPLACE Council Bluffs, Iowa
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Rosalina Lords
RESIDENCE Idaho Falls Rt. 6
COLOR White AGE AT LAST BIRTHDAY 24 (Years)
BIRTHPLACE Vernal, Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn born alive at 5: P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) [Signature]
(Physician or midwife)

Address Idaho Falls, Ida.

Filed Nov 16 1924

Registrar.

Registrar

2

CERTIFICATE OF BIRTH

Registration District No. 13608

Local Authority No.

(Certificate of no value when for name of child)

Date of birth

(Month) (Day)

Year

Number of children born to mother

and in order of birth

Sex

(M/F)

What postnatal action was taken in respect of this child?

Number of stills of this mother now living, including present birth

MOTHER

Full name

Residence

Color

Age at last birthday

Birthplace

Occupation

FATHER

Full name

Residence

Color

Age at last birthday (Year)

Birthplace

Occupation

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born on the day of the month of the year.

(Signature)

(Indicated as required)

When there was no attending physician or midwife, then the birth was attended by a qualified person, who should state the name and position of the person attending.

Address

Vertical text on the right edge of the page, likely a page number or reference code.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in separate of birth stated.

314-181-010-553
PLACE OF BIRTH

County of Bannock RECEIVED DEPARTMENT OF PUBLIC WELFARE
City of Idaho Falls DEC 10 1924 BUREAU OF VITAL STATISTICS
BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH 126709

No. _____ St. _____ District No. 73 State File No. _____
Hospital _____ Primary Registration District No. 214 Local Registrar's No. 424

FULL NAME OF CHILD Full name - Caughie
(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? yes Date of birth Dec 1 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME	<u>Harry Caughie</u>	FULL MAIDEN NAME	<u>Dr. Nelson</u>
RESIDENCE	<u>Idaho Falls Ida.</u>	RESIDENCE	<u>Idaho Falls Ida.</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>30</u> (Years)	AGE AT LAST BIRTHDAY	<u>27</u> (Years)
BIRTHPLACE	<u>Denver Col</u>	BIRTHPLACE	<u>Idaho Falls Ida</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at Idaho Falls N. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1924

(Signature) Harry Caughie
Parent
(Physician or midwife)

Address Idaho Falls Ida.
Filed Dec 3 1924 W. H. H. H.
Registrar. Registrar.

005321

Horizontal Electrical No.

Primary Hypertension Dis

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

1. General
 2. Specific
 3. Particular
 4. Detail
 5. Example
 6. Illustration
 7. Comparison
 8. Contrast
 9. Analogy
 10. Metaphor
 11. Simile
 12. Personification
 13. Hyperbole
 14. Oxymoron
 15. Irony
 16. Sarcasm
 17. Allegory
 18. Synecdoche
 19. Metonymy
 20. Onomatopoeia
 21. Alliteration
 22. Assonance
 23. Consonance
 24. Rhyme
 25. Repetition
 26. Parallelism
 27. Antithesis
 28. Chiasm
 29. Polysyndeton
 30. Asyndeton
 31. Anaphora
 32. Epanaphora
 33. Epiphora
 34. Prolepsis
 35. Hyperbaton
 36. Chiasm
 37. Polysyndeton
 38. Asyndeton
 39. Anaphora
 40. Epanaphora
 41. Epiphora
 42. Prolepsis
 43. Hyperbaton
 44. Chiasm
 45. Polysyndeton
 46. Asyndeton
 47. Anaphora
 48. Epanaphora
 49. Epiphora
 50. Prolepsis
 51. Hyperbaton
 52. Chiasm
 53. Polysyndeton
 54. Asyndeton
 55. Anaphora
 56. Epanaphora
 57. Epiphora
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 59. Hyperbaton
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 66. Prolepsis
 67. Hyperbaton
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 82. Prolepsis
 83. Hyperbaton
 84. Chiasm
 85. Polysyndeton
 86. Asyndeton
 87. Anaphora
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 89. Epiphora
 90. Prolepsis
 91. Hyperbaton
 92. Chiasm
 93. Polysyndeton
 94. Asyndeton
 95. Anaphora
 96. Epanaphora
 97. Epiphora
 98. Prolepsis
 99. Hyperbaton
 100. Chiasm
 101. Polysyndeton
 102. Asyndeton
 103. Anaphora
 104. Epanaphora
 105. Epiphora
 106. Prolepsis
 107. Hyperbaton
 108. Chiasm
 109. Polysyndeton
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 117. Polysyndeton
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 133. Polysyndeton
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 140. Chiasm
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 146. Prolepsis
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 149. Polysyndeton
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 157. Polysyndeton
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 170. Prolepsis
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 172. Chiasm
 173. Polysyndeton
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 175. Anaphora
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 180. Chiasm
 181. Polysyndeton
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 185. Epiphora
 186. Prolepsis
 187. Hyperbaton
 188. Chiasm
 189. Polysyndeton
 190. Asyndeton
 191. Anaphora
 192. Epanaphora
 193. Epiphora
 194. Prolepsis
 195. Hyperbaton
 196. Chiasm
 197. Polysyndeton
 198. Asyndeton
 199. Anaphora
 200. Epanaphora
 201. Epiphora
 202. Prolepsis
 203. Hyperbaton
 204. Chiasm
 205. Polysyndeton
 206. Asyndeton
 207. Anaphora
 208. Epanaphora
 209. Epiphora
 210. Prolepsis
 211. Hyperbaton
 212. Chiasm
 213. Polysyndeton
 214. Asyndeton
 215. Anaphora
 216. Epanaphora
 217. Epiphora
 218. Prolepsis
 219. Hyperbaton
 220. Chiasm
 221. Polysyndeton
 222. Asyndeton
 223. Anaphora
 224. Epanaphora
 225. Epiphora
 226. Prolepsis
 227. Hyperbaton
 228. Chiasm
 229. Polysyndeton
 230. Asyndeton
 231. Anaphora
 232. Epanaphora
 233. Epiphora
 234. Prolepsis
 235. Hyperbaton
 236. Chiasm

Leaves of fern have collector label attached to

divid income adjustment system and is billable in advance.

1998

UNION



104-10000

MONTAUDO

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

2. I personally verified that I attended the birth of this child, who was

1. The first of these is the fact that the
2. second of these is the fact that the
3. third of these is the fact that the
4. fourth of these is the fact that the
5. fifth of these is the fact that the
6. sixth of these is the fact that the
7. seventh of these is the fact that the
8. eighth of these is the fact that the
9. ninth of these is the fact that the
10. tenth of these is the fact that the

591 .
JAN 1954

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19.

that I last saw h. alive on 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

No medical attendance

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19. 24 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

494-016-018-315
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Canyon
City of Nampa
No. 424-4517 St. BUREAU OF VITAL STATISTICS District No. 7 State File No. 126744
Hospital _____ Primary Registration District No. 1006 Local Registrar's No. 107
FULL NAME OF CHILD "Infant" Stillborn
(Certificate of no value without full name of child)

Sex of Child	Twin Triplet or other? <u> </u> and { Number in order of birth <u> </u> (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of birth <u>11-16-24</u> 19 <u>24</u> (Month) (Day) (Year)
--------------	---	------------------------	--

What bactericidal solution was used in eyes? S
Number of child of this mother, including present birth 28 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Ephraim J. Demick
RESIDENCE Nampa - Ida
COLOR White AGE AT LAST BIRTHDAY 43 (Years)
BIRTHPLACE Idaho
OCCUPATION Stock man

MOTHER
FULL MAIDEN NAME Emma D. Lane
RESIDENCE Nampa - Ida
COLOR White AGE AT LAST BIRTHDAY 42 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 8 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 192____

Registrar.

(Signature) Geo B. Proctor
Physic
(Physician or midwife)
Address Dec 1 1924
Filed 4 Max Kerby
Registrar.

UNCLASSIFIED
DATE 11-11-2011 BY 60322 UCBAW/BJS
THIS DOCUMENT CONTAINS NEITHER RECOMMENDATIONS NOR
CONCLUSIONS OF THE FBI. IT IS THE PROPERTY OF THE FBI
AND IS LOANED TO YOUR AGENCY; IT AND ITS CONTENTS ARE NOT
TO BE DISTRIBUTED OUTSIDE YOUR AGENCY.

CERTIFICATE OF BIRTH

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

County of San Diego
City of San Diego
No. 12345
Hospital San Diego General Hospital
Maternity Registration District No. 100
Local Registrar John Doe

Full name of child John Doe
Sex of child Male
Date of birth 12/12/1945
Place of birth San Diego, California
It is hereby certified that the above is a true and correct copy of the original record.

What pathological condition was noted at birth? None
Number of stills of this mother, including previous births 1
Number of stills of this mother, including previous stills 1

FATHER		MOTHER	
NAME	RESIDENCE	NAME	RESIDENCE
<u>John Doe</u>	<u>San Diego, California</u>	<u>John Doe</u>	<u>San Diego, California</u>
DATE OF BIRTH	COLOR	DATE OF BIRTH	COLOR
<u>12/12/1945</u>	<u>White</u>	<u>12/12/1945</u>	<u>White</u>
BIRTHPLACE	OCCUPATION	BIRTHPLACE	OCCUPATION
<u>San Diego, California</u>	<u>None</u>	<u>San Diego, California</u>	<u>None</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of the above named child on the date and at the place above stated.

(Physician or midwife)
Signature John Doe
Date 12/12/1945

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

463-138-014-413
PLACE OF BIRTH

STATE OF IDAHO

RECEIVED DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Canyon

City of Parma

DEC 10 1924

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

126784

No. _____

St. _____

Registration District No. 9

State File No. _____

Hospital _____

Primary Registration District No. 2007

Local Registrar's No. 95-

FULL NAME OF CHILD Stellarn Molar

(Certificate of no value without full name of child)

Sex of Child Male

Twin
Triplet
or other?

and

Number
in order
of birth
(To be answered only in event of plural births)

Legiti-
mate? Yes

Date of
birth Oct 30 1924

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth _____

Number of child of this mother now living, including present birth _____

FULL
NAME

FATHER

Clarence Molar

RESIDENCE

Parma

COLOR

White

AGE AT LAST
BIRTHDAY

34
(Years)

BIRTHPLACE

Kau

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Lottie Dutton

RESIDENCE

Parma

COLOR

White

AGE AT LAST
BIRTHDAY

31
(Years)

BIRTHPLACE

Id.

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn { born alive } at 4 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) J. M. White

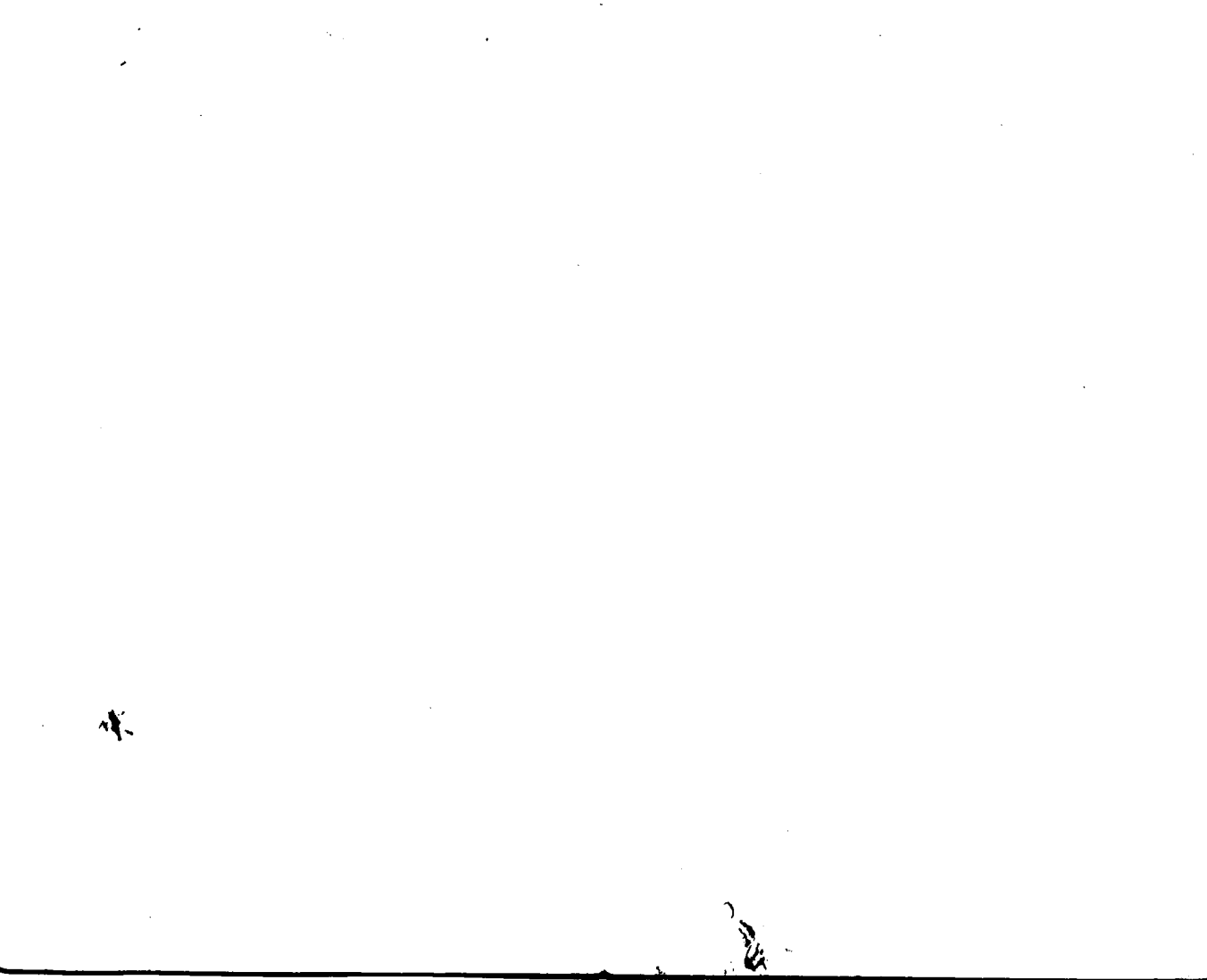
(Physician or midwife)

Address Parma, Ida

Filed 12-1 1924

Registrar.

Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

269-222-214-753
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

126826

County of Cassia
City of Cabley

RECEIVED

CERTIFICATE OF BIRTH

S

No. 122 St. Registration District No. 122 State File No. XXX

Hospital STATISTICS Primary Registration District No. 2149 Local Registrar's No. 1

FULL NAME OF CHILD Theresa Jensen

(Certificate of no value without full name of child)

Sex of Child <u>female</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>2</u>	Legitimacy <u>2</u>	Date of birth <u>Sept 2 - 1924</u> (Month) (Day) (Year)
----------------------------	-----------------------------------	-----------------------------------	---------------------	--

What bactericidal solution was used in eyes? Ag. No. 3

Number of child of this mother, including present birth ONE Number of child of this mother now living, including present birth 1

FATHER		MOTHER	
FULL NAME <u>Chris Jensen</u>	FULL MAIDEN NAME <u>Liona Jensen</u>		
RESIDENCE <u>Cabley, Id.</u>	RESIDENCE <u>Cabley, Idaho</u>		
COLOR <u>white</u>	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)	AGE AT LAST BIRTHDAY <u>26</u> (Years)
BIRTHPLACE <u>Denmark</u>	BIRTHPLACE <u>Wah</u>		
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at P. on the date above stated. M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) M. H. Gibson

(Physician or midwife)

Give names added from a supplemental report.

Address Cabley, Idaho

Filed Nov 1 1924

Registrar.

Registrar.

.....201

"When there was no attending physician or midwife, then the father, mother or neighbor should make the return. A child born alive is one that neither mother nor nurse ever evidences of life after birth."

When there was no attending physician or midwife, then the latter, however, should make the fetal position of the child is one that neither condition nor shows other evidence of life after birth.

on the date above stated. I hereby certify that

I hereby certify that I attended the birth of this child, who was (8511) born

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

DECLARATION

৯০৫০০

YACHTING AT LAST

अनुसूचित जाति

487
- 144215

HTA9

4409

RESPONSE

ՀԵՐԱՆՈՒՄ

DISPATCH

KONTAKUDDO

Number of child

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

What bacteriological solution was used in great

APR 18 1964

10 192

10-10-44

1760 81

Address:

20 7150
4100



FOOT NAME OF CARD

1371571

9410812

NO.

Local Registrar

20-2

7: 6

1. *Chlorophyll a* (Chl *a*)

2

CERTIFICATE OF BIRTH

DEPARTMENT OF AGRICULTURE
BUREAU OF CENSUS

43833

CERTIFICATE OF DEATH

47716

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Sage*City of *Carney*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

NOV 2

BUREAU OF
STATISTICS

2. FULL NAME

Registration District No. *120*Primary Registration District No. *2199*(No. *15*)

St.)

File No. *XIV*Registered No. *3*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*

(Write the word.)

6. DATE OF BIRTH

Sept (Month)*2nd* (Day)*1924* (Year)

7. AGE

still borne

Yrs. Mos. ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Nov 1st 1924

19

24

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept (Month)*2nd* (Day)*1924* (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Baby was stillborn, cause unknown

(Duration)

Yrs.

mos.

ds.

Contributory (Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

M. D.

Sept 12 1924

(Address)

Carney Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Carney Idaho**Sept 12 1924*

20. UNDERTAKER

ADDRESS

*Carney**Carney Idaho*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH 869-118-19-296 STATE OF MISSISSIPPI
County of Challis DEPARTMENT OF PUBLIC HEALTH
City of Challis BUREAU OF VITAL STATISTICS
No. 105 CERTIFICATE OF BIRTH **S126844**
St. 2186 Registration District No. 25 State File No. 25
Hospital 2186 Local Registrar's No. 25
Primary Registration District No. 2186 Local Registrar's No. 25
FULL NAME OF CHILD Chas William Horn
(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth (To be answered only in event of plural births)	Legitimate? <u>Yes</u>	Date of birth <u>Nov 18</u> , 192 <u>4</u> (Month) (Day) (Year)
-----------------------	---	---	---------------------------	--

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth <u>3</u>		Number of child of this mother now living, including present birth <u>3</u>	
FATHER FULL NAME <u>Chas P Horn</u> RESIDENCE <u>Challis</u> COLOR <u>Wh</u> AGE AT LAST BIRTHDAY <u>30</u> (Years) BIRTHPLACE <u>Idaho</u> OCCUPATION <u>Chauffeur</u>		MOTHER FULL MAIDEN NAME <u>Laura Brown</u> RESIDENCE <u>Challis</u> COLOR <u>Wh</u> AGE AT LAST BIRTHDAY <u>32</u> (Years) BIRTHPLACE <u>Idaho</u> OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at Twelve night
on the date above stated. { Stillborn }

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Mrs Julia Finkbeiner
Midwife
(Physician or midwife)

Give names added from a supplemental report.

Address Challis
Filed Challis 1924 Hazel Jones
Nov 18 1924 Registrar.

When there was no attending physician of mind that the father house- hold of mind should make the return. A. William child is one that mother does not show other evidence of being ill.

100

NAME	NAME
RESIDENCE	RESIDENCE
COLOR	COLOR
BIRTHPLACE	BIRTHPLACE
OCCUPATION	OCCUPATION
DATE OF LAST BIRTHDAY	DATE OF LAST BIRTHDAY

[illegible][illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH
County of Latah
City of Challis
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas William Horn

RECEIVED
DEC 8 1924
BUREAU OF VITAL STATISTICS
Registration District No. 108
Primary Registration District No. 2186
(No. St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
State File No. 47731
Local Registrar's No. 16
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS
3. SEX M
4. COLOR OR RACE Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
6. DATE OF BIRTH Nov 18 1924
7. AGE Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).
9. BIRTHPLACE (State or Country) Idaho
10. NAME OF Father Charles P Horn
11. BIRTHPLACE OF FATHER (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Laura Brown
13. BIRTHPLACE OF MOTHER (State or Country) Mo
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)
15. Filed Nov 18 1924 Hazel Jones
Local Registrar

MEDICAL CERTIFICATE OF DEATH
16. DATE OF DEATH Nov 18 1924
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 19 to 19 ,
that I last saw h alive on 19 ,
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Stillborn
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) M. D.
19 (Address)
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or usual residence
19. PLACE OF BURIAL OR REMOVAL Challis DATE OF BURIAL Nov 19 1924
20. UNDERTAKER Relatives ADDRESS Challis

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Salesman, (b) Grocery;** (a) **Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia;** **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles;** **Whooping cough;** **Chronic valvular heart disease;** **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **20 ds.;** **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning;** **struck by railway train—accident;** **Revolver wound of head—homicide;** **Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

248-1241028-413
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Kootenai RECEIVED
City of Rathdrum DEC 10 1924
No. 30 BUREAU OF VITAL STATISTICS
Registration District No. 30 State File No. 126956
Hospital _____ Primary Registration District No. 105 Local Registrar's No. 1171
FULL NAME OF CHILD James named Buchmester
(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin Triplet or other? _____	and { Number in order of birth _____ }	Legitimate? <u>yes</u>	Date of birth <u>Nov. 24 1924</u>
(To be answered only in event of plural births)			(Month) (Day) (Year)	

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 6

Number of child of this mother now living, including present birth 5

FATHER
FULL NAME Fred. W. Buchmester

MOTHER
FULL MAIDEN NAME Vesta E. Mathews

RESIDENCE Hayden Lake, Idaho

RESIDENCE Hayden Lake, Idaho

COLOR white AGE AT LAST BIRTHDAY 44
(Years)

COLOR white AGE AT LAST BIRTHDAY 33
(Years)

BIRTHPLACE Ill.

BIRTHPLACE Wash.

OCCUPATION farmer

OCCUPATION housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 8.00 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Frank Henry

(Physician or midwife)

Address Rathdrum Idaho

Filed 12/8 1924 W. D. Druman

Registrar.

Registrar.

RECEIVED
OFFICE OF THE ATTORNEY GENERAL
STATE OF NEW YORK

DECLARATION OF NATURALIZATION

IN SENATE
JANUARY 1900

Primary Election held at the residence of the declarant on the 1st day of January, 1900.

(Declaration made at the residence of the declarant on the 1st day of January, 1900.)

State of New York

County of New York

(Municipality)

(Name of the declarant)

(Address of the declarant)

(Occupation of the declarant)

(Date of birth)

(Place of birth)

(Date of arrival in the United States)

(Date of declaration)

(Signature of the declarant)

(Signature of the witness)

(Signature of the judge)

(Signature of the clerk)

(Signature of the recorder)

(Signature of the sheriff)

(Signature of the coroner)

(Signature of the assessor)

RECEIVED
OFFICE OF THE ATTORNEY GENERAL
STATE OF NEW YORK

DECLARATION OF NATURALIZATION

IN SENATE
JANUARY 1900

Primary Election held at the residence of the declarant on the 1st day of January, 1900.

(Declaration made at the residence of the declarant on the 1st day of January, 1900.)

State of New York

County of New York

(Municipality)

(Name of the declarant)

(Address of the declarant)

(Occupation of the declarant)

(Date of birth)

(Place of birth)

(Date of arrival in the United States)

(Date of declaration)

(Signature of the declarant)

(Signature of the witness)

(Signature of the judge)

(Signature of the clerk)

(Signature of the recorder)

(Signature of the sheriff)

(Signature of the coroner)

(Signature of the assessor)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 20Primary Registration District No. 1057

(No. St.)

State File No. 18417Local Registrar's No. 7468

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

(no name) Bukrmeister

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDsingle
(Write the word)

6. DATE OF BIRTH

Nov. 24. 1924

(Month)

(Day)

(Year)

7. AGE

Still born

Yrs. Mos. ds.

IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).None

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FatherLeed W. Bukrmeister11. BIRTHPLACE
OF FATHER

(State or Country)

Id.12. MAIDEN NAME
OF MOTHERVesta E. Matthews13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leed W. Bukrmeister

(Address)

Hayden Lake, Id.

15.

Filed

Jan 6.

1924

C. L. Case

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 24.

(Month)

(Day)

24

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Stillborn to

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

malpresentation and
overgrown - 10 months
gestation
(Duration) yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Frank M. D.

1924 (Address)

Re. Hayden Lake, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

First Free Cemetery

DATE OF BURIAL

Nov 25 1924

20. UNDERTAKER

C. L. Case

ADDRESS

Hayden Lake, Id.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

Can one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

295-1280228-454

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH 126958

County of Kootenai

City of Spirit Lake

No. _____ St. _____

Registration District No. 30

State File No. _____

Hospital _____

Primary Registration District No. 1057

Local Registrar's No. 1173

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child

male

Twin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legitimate?

Yes

Date of birth

Mar 28 1924

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 8

Number of child of this mother now living, including present birth 3

FULL NAME

FATHER

Phillip King

RESIDENCE

Spirit Lake

COLOR

White

AGE AT LAST BIRTHDAY

33

(Years)

BIRTHPLACE

Leadville

OCCUPATION

Mill and Oversee

FULL MAIDEN NAME

MOTHER

Mary Bernaniche

RESIDENCE

Spirit Lake

COLOR

White

AGE AT LAST BIRTHDAY

43

(Years)

BIRTHPLACE

Wis

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 1030 P M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1924

(Signature)

R. S. Nelson, M.D.

(Physician or midwife)

Address

Spirit Lake, Id.

Filed

12/8

1924

O. D. Brennan

Registrar.

Registrar.

Regulation District No. 12

Form 7-60 (Rev. 1-25-60)

Corollary 4.1. *If \mathcal{C} is a class of structures with no finite members, then \mathcal{C} is not a variety.*

[illegible]

failure of these new relations between them

11-10-1964

David Brown, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681

RESIDENCE
NAME
MAIDEN
FULL

FATHER

EEASTA 30A
YACHTS

YADITRUE

BIRTHPLACE

SECRET

OCCUPATION

PHYSICIAN OR MIDWIFE

CERTIFICATE OF ATTENDING

SECRET

into this in 1944 and 1945. I had three children, I had a wife and two children.

1. DATE OF EXAMINATION _____

2. NAME OF PHYSICIAN _____

3. NAME OF PATIENT _____

4. ADDRESS OF PATIENT _____

5. DATE OF BIRTH _____

6. SEX _____

7. HEIGHT _____

8. WEIGHT _____

9. TEMPERATURE _____

10. PULSE _____

11. BLOOD PRESSURE _____

12. RESPIRATIONS _____

13. HEART _____

14. LUNGS _____

15. ABDOMEN _____

16. NEUROLOGICAL _____

17. SKIN _____

18. GENERAL APPEARANCE _____

19. DIAGNOSIS _____

20. TREATMENT _____

21. PROGNOSIS _____

22. REMARKS _____

23. SIGNATURE OF PHYSICIAN _____

24. DATE OF SIGNATURE _____

25. NAME OF PATIENT _____

26. ADDRESS OF PATIENT _____

27. DATE OF BIRTH _____

28. SEX _____

29. HEIGHT _____

30. WEIGHT _____

31. TEMPERATURE _____

32. PULSE _____

33. BLOOD PRESSURE _____

34. RESPIRATIONS _____

35. HEART _____

36. LUNGS _____

37. ABDOMEN _____

38. NEUROLOGICAL _____

39. SKIN _____

40. GENERAL APPEARANCE _____

41. DIAGNOSIS _____

42. TREATMENT _____

43. PROGNOSIS _____

44. REMARKS _____

45. SIGNATURE OF PHYSICIAN _____

46. DATE OF SIGNATURE _____

47. NAME OF PATIENT _____

48. ADDRESS OF PATIENT _____

49. DATE OF BIRTH _____

50. SEX _____

51. HEIGHT _____

52. WEIGHT _____

53. TEMPERATURE _____

54. PULSE _____

55. BLOOD PRESSURE _____

56. RESPIRATIONS _____

57. HEART _____

58. LUNGS _____

59. ABDOMEN _____

60. NEUROLOGICAL _____

61. SKIN _____

62. GENERAL APPEARANCE _____

63. DIAGNOSIS _____

64. TREATMENT _____

65. PROGNOSIS _____

66. REMARKS _____

67. SIGNATURE OF PHYSICIAN _____

68. DATE OF SIGNATURE _____

69. NAME OF PATIENT _____

70. ADDRESS OF PATIENT _____

71. DATE OF BIRTH _____

72. SEX _____

73. HEIGHT _____

74. WEIGHT _____

75. TEMPERATURE _____

76. PULSE _____

77. BLOOD PRESSURE _____

78. RESPIRATIONS _____

79. HEART _____

80. LUNGS _____

81. ABDOMEN _____

82. NEUROLOGICAL _____

83. SKIN _____

84. GENERAL APPEARANCE _____

85. DIAGNOSIS _____

86. TREATMENT _____

87. PROGNOSIS _____

88. REMARKS _____

89. SIGNATURE OF PHYSICIAN _____

90. DATE OF SIGNATURE _____

91. NAME OF PATIENT _____

92. ADDRESS OF PATIENT _____

93. DATE OF BIRTH _____

94. SEX _____

95. HEIGHT _____

96. WEIGHT _____

97. TEMPERATURE _____

98. PULSE _____

99. BLOOD PRESSURE _____

100. RESPIRATIONS _____

101. HEART _____

102. LUNGS _____

103. ABDOMEN _____

104. NEUROLOGICAL _____

105. SKIN _____

106. GENERAL APPEARANCE _____

107. DIAGNOSIS _____

108. TREATMENT _____

109. PROGNOSIS _____

110. REMARKS _____

111. SIGNATURE OF PHYSICIAN _____

112. DATE OF SIGNATURE _____

113. NAME OF PATIENT _____

114. ADDRESS OF PATIENT _____

115. DATE OF BIRTH _____

116. SEX _____

117. HEIGHT _____

118. WEIGHT _____

119. TEMPERATURE _____

120. PULSE _____

121. BLOOD PRESSURE _____

122. RESPIRATIONS _____

123. HEART _____

124. LUNGS _____

125. ABDOMEN _____

126. NEUROLOGICAL _____

127. SKIN _____

128. GENERAL APPEARANCE _____

129. DIAGNOSIS _____

130. TREATMENT _____

131. PROGNOSIS _____

132. REMARKS _____

133. SIGNATURE OF PHYSICIAN _____

134. DATE OF SIGNATURE _____

135. NAME OF PATIENT _____

136. ADDRESS OF PATIENT _____

137. DATE OF BIRTH _____

138. SEX _____

139. HEIGHT _____

140. WEIGHT _____

141. TEMPERATURE _____

142. PULSE _____

143. BLOOD PRESSURE _____

144. RESPIRATIONS _____

145. HEART _____

146. LUNGS _____

147. ABDOMEN _____

148. NEUROLOGICAL _____

149. SKIN _____

150. GENERAL APPEARANCE _____

151. DIAGNOSIS _____

152. TREATMENT _____

153. PROGNOSIS _____

154. REMARKS _____

155. SIGNATURE OF PHYSICIAN _____

156. DATE OF SIGNATURE _____

157. NAME OF PATIENT _____

158. ADDRESS OF PATIENT _____

159. DATE OF BIRTH _____

160. SEX _____

161. HEIGHT _____

162. WEIGHT _____

163. TEMPERATURE _____

164. PULSE _____

165. BLOOD PRESSURE _____

166. RESPIRATIONS _____

167. HEART _____

168. LUNGS _____

169. ABDOMEN _____

170. NEUROLOGICAL _____

171. SKIN _____

172. GENERAL APPEARANCE _____

173. DIAGNOSIS _____

174. TREATMENT _____

175. PROGNOSIS _____

176. REMARKS _____

177. SIGNATURE OF PHYSICIAN _____

178. DATE OF SIGNATURE _____

179. NAME OF PATIENT _____

180. ADDRESS OF PATIENT _____

181. DATE OF BIRTH _____

182. SEX _____

183. HEIGHT _____

184. WEIGHT _____

185. TEMPERATURE _____

186. PULSE _____

187. BLOOD PRESSURE _____

188. RESPIRATIONS _____

189. HEART _____

190. LUNGS _____

191. ABDOMEN _____

192. NEUROLOGICAL _____

193. SKIN _____

194. GENERAL APPEARANCE _____

195. DIAGNOSIS _____

196. TREATMENT _____

197. PROGNOSIS _____

198. REMARKS _____

199. SIGNATURE OF PHYSICIAN _____

200. DATE OF SIGNATURE _____

201. NAME OF PATIENT _____

202. ADDRESS OF PATIENT _____

203. DATE OF BIRTH _____

204. SEX _____

205. HEIGHT _____

206. WEIGHT _____

207. TEMPERATURE _____

208. PULSE _____

209. BLOOD PRESSURE _____

210. RESPIRATIONS _____

211. HEART _____

212. LUNGS _____

213. ABDOMEN _____

214. NEUROLOGICAL _____

215. SKIN _____

216. GENERAL APPEARANCE _____

217. DIAGNOSIS _____

218. TREATMENT _____

219. PROGNOSIS _____

220. REMARKS _____

22

I am not sure if I should be in the office, who was
 (signature)
 I am not sure if I should be in the office, who was
 (signature)

289705A

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

712-205029-141
PLACE OF BIRTH

County of Latate
City of Muscow

No. _____ St. _____

Hospital _____

RECEIVED
DEC 8 1924
BUREAU OF VITAL STATISTICS
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 101

File No. 126981

Primary Registration District No. 1011

Registered No. 138

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>ye</u>	Date of birth <u>Oct 5</u> 192 <u>4</u> (Month) (Day) (Year)
----------------------------	------------------------------	-----------	--------------------------------	-----------------------	---

(To be answered only in event of plural births)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 4

FULL NAME <u>Thomas Jabbora</u>	FATHER	FULL MAIDEN NAME <u>Effie C. Jabbora</u>	MOTHER
RESIDENCE <u>Muscow</u>		RESIDENCE <u>Muscow</u>	
COLOR _____	AGE AT LAST BIRTHDAY <u>38</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)
BIRTHPLACE <u>Syria</u>		BIRTHPLACE <u>Utah</u>	
OCCUPATION <u>Laborer</u>		OCCUPATION <u>House wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____ at _____ M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

J. H. Eldridge
(Born alive or stillborn)

(Physician or midwife)

Give names added from a supplemental report.

Address

Filed Nov 16 1924

W. H. Caruthers
Registrar.

Registrar.

2

UNITED STATES DEPARTMENT OF HEALTH
AND HUMAN SERVICES
STATISTICAL CENTER

STATE OF BIRTH

150881

No.

101

Registration District

101

Registration No.

101

Place of residence with name of street

DATE OF BIRTH

Date of birth

1911

Month

10

Day

10

MOTHER

AGE AT LAST
BIRTHDAY

101

101

101

STATE OF ATTENDANCE OF PHYSICIAN

101

(This name should be from a supplemental report)

Advised

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

47466

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 601

County of Latah

Primary Registration District No. 1011

City of MOSCOW

(No. _____, _____ St.)

File No. _____

Registered No. 51

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Jabbora

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

Serian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Child

(Write the word.)

6. DATE OF BIRTH

Oct. 5

1924

(Month)

(Day)

(Year)

7. AGE

Stillborn

mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Thomas J. Jabbora

11. BIRTHPLACE OF FATHER

(State or Country) Seria

12. MAIDEN NAME OF MOTHER

Effie Junehke

13. BIRTHPLACE OF MOTHER

(State or Country) Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas J. Jabbora

(Address) Moscow, Ida.

15.

Filed Oct. 6 1924

M. Caruthers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 5

1924

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191... to 191...

that I last saw h... alive on 191...

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still born (5 months)

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Clark M. D.

1924 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. mos. days. In the State... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Moscow

Oct. 6 1924

20. UNDERTAKER

ADDRESS

H. R. Short

Moscow

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Cancer, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

714-217-042-213
PLACE OF BIRTH

RECEIVED
DEC 3 1924
BUREAU OF VITAL STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Twin Falls
City of Twin Falls
No. _____ St. _____ Registration District No. 37 State File No. 127193
Hospital T.F. Co. Gen. Primary Registration District No. 1085 Local Registration No. _____
FULL NAME OF CHILD Babe Girl Gambriel Skithorn
(Certificate of no value without full name of child)
Sex of Child female { Twin } and { Number } Legiti- Date of Nov. 17 1924
Child Triplet } { in order } mate? yes birth (Month) (Day) (Year)
or other? } { of birth }
(To be answered only in event of plural births)
What bactericidal solution was used in eyes? _____
Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0
FULL NAME FATHER Harley D. Gambriel FULL MAIDEN NAME MOTHER Rose Kalousek
RESIDENCE Filer, Ida. RESIDENCE Filer, Ida.
COLOR white AGE AT LAST BIRTHDAY 22 COLOR white AGE AT LAST BIRTHDAY 21
(Years) (Years)
BIRTHPLACE North Platte Neb. BIRTHPLACE North Dakota
OCCUPATION Laborer OCCUPATION Wife
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of this child, who was born alive at Stillhorn 335 A. M.
on the date above stated.
(Signature) H. A. Swigert, M.D.
(Physician or midwife)
Give names added from a supplemental report. _____
_____, 192____

Registrar. Filer, Idaho
Address _____
Filed Dec. 1- 1924 John F. Coughlin
Registrar.

2

STATE OF NEW YORK
 DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

1921

State of New York

1921

County of ...

(Certificate of the birth of a child)

Sex ☐ Male ☐ Female
 Date of Birth (Month) (Day) (Year)

Weight

Length

Number of child of this mother now living including present birth

Full Name

Residence

Color

Birthplace

Occupation

Age at Birth

BIRTHDAY

Signature

Signature

(Date)

CERTIFICATE OF ATTENDING PHYSICIAN

I hereby certify that I attended the birth of this child, who was born on ... at ...

(Signature)

Physician's Certificate

1921

1921

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. **RECEIVED**
Registration District No. 37
County of Blaine Primary Registration District No. 1085
City of Blaine **BUREAU OF VITALS** County General Hospital. (St.)

File No. 47887
Registered No. 1276

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Gambrel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)6. DATE OF BIRTH. Nov. 17 1924
(Month) (Day) (Year)7. AGE Still Born
IF LESS than 1 day how many hrs. or min. 2]8. OCCUPATION —

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE Idaho
(State or Country)10. NAME OF FATHER A. J. Gambrel11. BIRTHPLACE OF FATHER Nebraska
(State or Country)12. MAIDEN NAME OF MOTHER Rose Kalanick13. BIRTHPLACE OF MOTHER North Dakota
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. J. Gambrel(Address) Idaho15. John H. Hazle
Local RegistrarFiled Dec. 1 1924

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 17 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 17 1924 to Nov. 17 1924, that I last saw her on Nov. 17 1924 and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Prolapsed umbilical cord
1 Hour
(Duration) Yr. mos. ds.
Contributory Excessive breast delivery
(Secondary) 1 Hour
(Duration) Yr. mos. ds.
(Signed) G. A. Hargrave M. D.

Nov. 17 1924 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Doot CemeteryDATE OF BURIAL Nov. 17 192420. UNDERTAKER J. E. DrakeADDRESS Idaho

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

413-118642-365
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Twin Falls

DEC 3 1924

City of Twin Falls

CERTIFICATE OF BIRTH

127195

No. _____ St. Registration District No. 37 State File No. _____

Hospital T. F. Co. General Primary Registration District No. 1085 Local Registrar's No. _____

FULL NAME OF CHILD Harold Cooper Haskling

(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin Triplet or other? _____ } and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Nov. 19</u> 192 <u>4</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FULL NAME <u>Will Haskling</u>	FATHER
RESIDENCE <u>Filer, Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)
BIRTHPLACE <u>Alexander La.</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Ella Mae Connelly</u>	MOTHER
RESIDENCE <u>Filer, Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>35</u> (Years)
BIRTHPLACE <u>Bement, Ill.</u>	
OCCUPATION <u>Nurs.</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive { Stillborn } at 6 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) Howardson
physician
(physician or midwife)

Address Twin Falls, Ida.

Filed Dec. 1-24 1924
John Houghlin Registrar.

Registrar.

2

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D. C. 20535

REPORT OF INVESTIGATION

TO: DIRECTOR, FBI (100-388610)

FROM: SAC, NEW YORK (100-100000)

SUBJECT: [REDACTED]

RE: [REDACTED]

DATE: [REDACTED]

BY: [REDACTED]

CHARACTER OF CASE: [REDACTED]

CLASSIFICATION: [REDACTED]

STATUS: [REDACTED]

SYNOPSIS: [REDACTED]

DETAILS: [REDACTED]

CONCLUSIONS: [REDACTED]

RECOMMENDATIONS: [REDACTED]

ADMINISTRATIVE: [REDACTED]

OTHER: [REDACTED]

COPIES: [REDACTED]

APPROVAL: [REDACTED]

SPECIAL AGENT IN CHARGE

DATE: [REDACTED]

TIME: [REDACTED]

PLACE: [REDACTED]

BY: [REDACTED]

FOR: [REDACTED]

FILE: [REDACTED]

REMARKS: [REDACTED]

REFERENCE: [REDACTED]

NOTES: [REDACTED]

ADDITIONAL INFORMATION: [REDACTED]

COMMENTS: [REDACTED]

REMARKS: [REDACTED]

REMARKS: [REDACTED]

REMARKS: [REDACTED]

REMARKS: [REDACTED]

REMARKS: [REDACTED]

REMARKS: [REDACTED]

REMARKS: [REDACTED]

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37
 City of Twin Falls Primary Registration District No. 1085
 County, Idaho (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Walking

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 47875

Registered No. 1281

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant
 (Write the word.)

6. DATE OF BIRTH Nov 19 1924
 (Month) (Day) (Year)

7. AGE 0 Yrs. 0 Mos. 0 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Twin Falls

10. NAME OF FATHER

Will Walking

11. BIRTHPLACE OF FATHER

(State or Country) Louisiana

12. MAIDEN NAME OF MOTHER

Ella May

13. BIRTHPLACE OF MOTHER

(State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Will Walking

(Address) _____

15.

Filed Dec. 1-24 19

John F. Leighton
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 19 1924
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19 1924 to Nov 19 1924

that I last saw him alive on _____ 19____

and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) Harvillan

M. D.

Nov 21 1924

(Address) Twin Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Twin Falls

DATE OF BURIAL

11-20-1924

20. UNDERTAKER

J. Stewart

ADDRESS

Twin Falls

JUN 16 1938

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

614-106-00-413
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S-

County of Ada

City of Boise

No. St. Alphonsus St.

Registration District No. 2

State File No. 127282

Hospital St. Alphonsus

Primary Registration District No. 1347

Local Registrar's No. 128

FULL NAME OF CHILD

Baby Wade (stillborn)

(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>Dec 6</u> , 192 <u>4</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 2

Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Ross B. Wade

RESIDENCE Boise Idaho

COLOR White AGE AT LAST BIRTHDAY 44 (Years)

BIRTHPLACE Mo.

OCCUPATION Salesman

MOTHER
FULL MAIDEN NAME Berrie Wagley

RESIDENCE Boise Idaho

COLOR White AGE AT LAST BIRTHDAY 38 (Years)

BIRTHPLACE Ill.

OCCUPATION Rev.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 5 a. m. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Joe R. Munn

(Physician or midwife)

Give names added from a supplemental report.

Address Boise Idaho

Filed Dec 16 1924 P. H. Cratt

Registrar.

Registrar.

7-

STATE OF NEW YORK
DEPARTMENT OF SOCIAL WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

157385

2

Registration District No. _____

Local Registrar No. _____

(Certificate of no birth without full name of child)

Sex of child (male or female)
Date of birth (month and day)
Place of birth (city and county)

Was the child ever in the hospital?

Was the child ever in the hospital, including birth?

Number of child in this mother's family, including previous births

MOTHER

FULL NAME
MOTHER

RESIDENCE

FATHER

AGE AT LAST BIRTHDAY (years)

COLOR

BIRTHPLACE

OCCUPATION

OCCUPATION

SIGNATURE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born on _____ at _____

(Signature)

(Physician or Midwife)

Address

Location

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
— BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of AdaCity of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2Primary Registration District No. St. Alphonsus Hospital(No. 286)File No. 47902Registered No. 286

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Infant Wade

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMWhiteSingle

(Write the word.)

6. DATE OF BIRTH

Dec-6-1924

(Month)

(Day)

(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Boise Idaho

10. NAME OF FATHER

R. B. Wade

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Laurene Mackay

13. BIRTHPLACE OF MOTHER

(State or Country)

Delaware

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. B. Wade

(Address)

Boise Ida

15.

Filed

Dec. 619 24

Local Registrar

R. B. Wade

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Stillborn
Dec 6 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw h. alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn - result of
knot in umbilical cord
strangulating circulation

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Joe R. Summers M. D.

(Address)

Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris This Cemetery

DATE OF BURIAL

Dec 6 19 24

20. UNDERTAKER

Summers & Thib

ADDRESS

Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

PLACE OF BIRTH

653-115007469

RECEIVED

STATE OF IDAHO

Form V. S. No. 11—50m—7-23-23

DEPARTMENT OF PUBLIC WELFARE

County of Bernier

JAN 17 1925

BUREAU OF VITAL STATISTICS

City of PocatelloBUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

S 127451

Registration District No. 28

File No.

No. _____ St.

Hospital GeneralPrimary Registration District No. 2161Registered No. 6774

FULL NAME OF CHILD

StillbornSex of Child mTwin
Triplet
or other?

and

Number
in order
of birthLegiti-
mate?yesDate of
Birth12/15/24
(Month) (Day) (Year)FULL
NAME

FATHER

William B. DeelsFULL
MAIDEN
NAME

MOTHER

Esther - Moore

RESIDENCE

627 So Main Pocatello

RESIDENCE

627 So Main Pocatello

COLOR

WhiteAGE AT LAST
BIRTHDAY37
(Years)

COLOR

WhiteAGE AT LAST
BIRTHDAY38
(Years)

BIRTHPLACE

Baldor Cal.

BIRTHPLACE

Lewis Mass.

OCCUPATION

Cabinet maker

OCCUPATION

Home

WHAT BACTERICIDAL SOLUTION WAS USED IN CASE?

20% MercurochromeNumber of child of this mother, including present birth 3Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.Stillborn at 39 M.

(Born alive or stillborn)

*When there was no attending physician or
 midwife then the father, householder, etc.,
 should make this return. A stillborn child is
 one that neither breathes nor shows other evi-
 dence of life after birth.

(Signature)

Dr. Carl M. M.

Given names added from a supplemental report.

(Physician or midwife)

Address

Carlson Bldg. Pocatello Idaho

Filed

1-1 1925

Registrar.

Registrar.

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C. 20250

26 H

new
colony

**ALL
MAY**

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

1992

1994年12月15日

100-443887-100

Figure 1

2014年12月

[illegible]

DEPARTMENT OF PUBLIC WELFARE.

Boise, Idaho

JAN 20 1925

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth (CITY Pocatello
 (ST. 627-S. Main
 (COUNTY Idaho.

FILE NO. 127451DATE OF BIRTH Dec. 15-1924.SEX OF CHILD MaleFATHER W. B. Wells.MOTHER E. Esther Moren
(MAIDEN NAME)

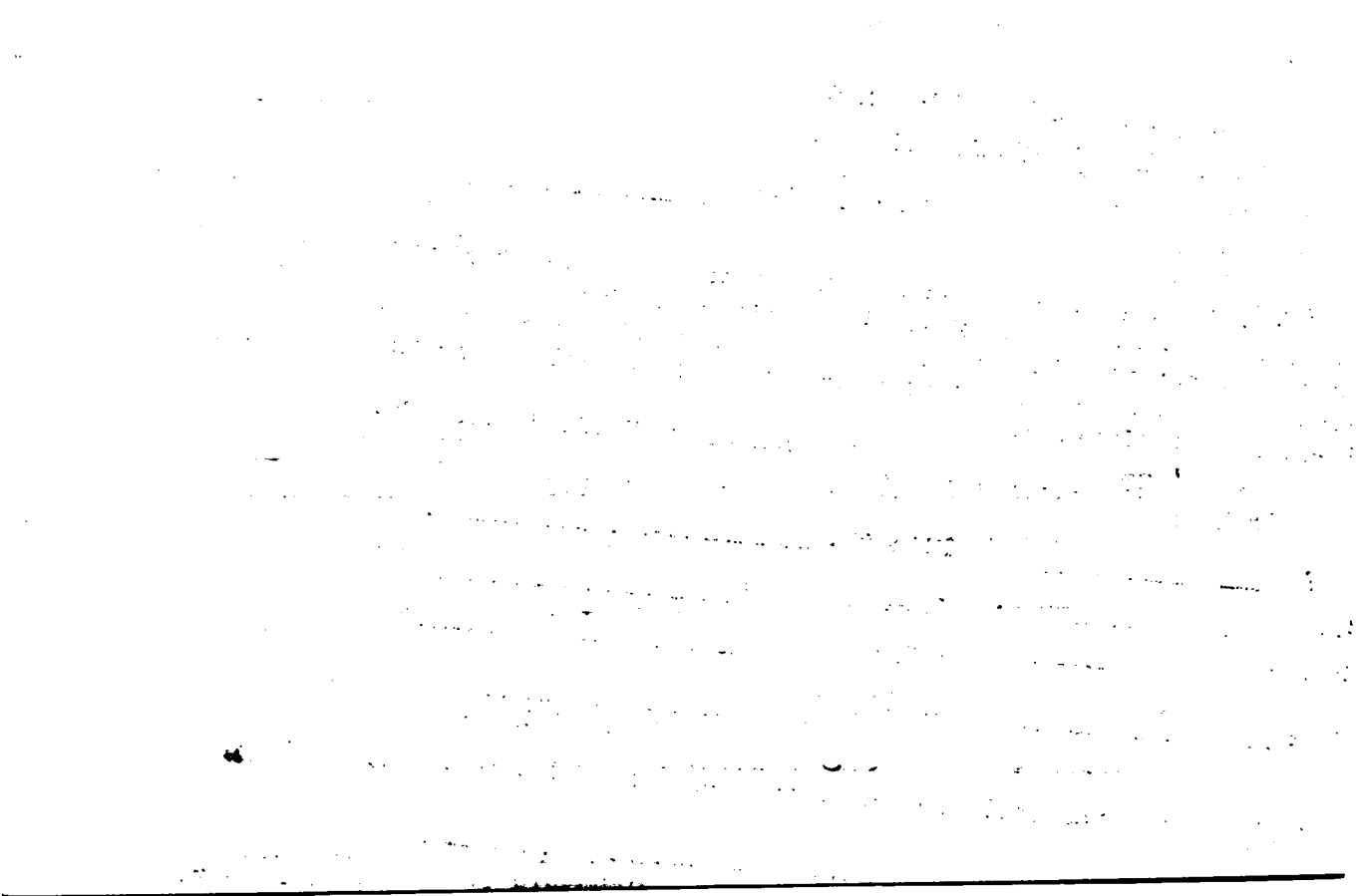
I HEREBY CERTIFY that the child herein described has been named:

Premature 6²/₇ months. Still born.

RECEIVED

JAN 20 1925

Mrs. W. B. Wells.
 Signature of Father or Mother.



551721 004-294
PLACE OF BIRTHSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bear Lake
 City of Raymond
 No. 52 St. Registration District No. 2136 State File No. 127499
 Hospital _____ Primary Registration District No. _____ Local Registrar's No. _____
 FULL NAME OF CHILD Evans

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>10-21</u> , 19 <u>24</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	-----------------------------	--

What bactericidal solution was used in eyes? noneNumber of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 1

FULL NAME <u>Asa E Evans</u>	FATHER	FULL MAIDEN NAME <u>Nora Kimball</u>	MOTHER
RESIDENCE <u>Raymond</u>		RESIDENCE <u>Raymond</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>43</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Rancher</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 8 a. m.
 on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) J. P. Gaerher

(Physician or midwife)

Address MontpelierFiled 12-31 1924

Registrar.

Registrar.

PLACE OF BIRTH

STATE OF CALIFORNIA
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

157400

(1)

FULL NAME OF CHILD

Sex of Child	Male
Date of Birth	1912
Time of Birth	11:00 AM
Place of Birth	San Francisco, California

When hospitalized, mention day week in event	
Number of child of this mother (including present birth)	1
FULL NAME OF FATHER	JOHN J. BAKER
FULL NAME OF MOTHER	MARY J. BAKER

Full name of child without full name of child	
Sex of Child	Male
Date of Birth	1912
Time of Birth	11:00 AM
Place of Birth	San Francisco, California

Number of child of this mother now living (including present birth)	1
FULL NAME OF FATHER	JOHN J. BAKER
FULL NAME OF MOTHER	MARY J. BAKER

COLOR	WHITE
BIRTHPLACE	San Francisco, California
OCCUPATION	
AGE AT LAST BIRTHDAY	1 Year

COLOR	WHITE
BIRTHPLACE	San Francisco, California
OCCUPATION	
AGE AT LAST BIRTHDAY	1 Year

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of the child who was born on the date above stated.

Signature: _____

(Physician or Midwife)

Date: _____

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE

S

1025 BUREAU OF VITAL STATISTICS

County of Bingham

City of Sterling

No. 316 109 006 519 St.

Registration District No. 116

State File No. 127624

Hospital

Primary Registration District No. 2195

Local Registrar's No. 877

FULL NAME OF CHILD Still born (Taggart)

(Certificate of no value without full name of child)

Sex of
Child male

Twin
Triplet
or other?

} and {

Number
in order
of birth

Legiti-
mate? yes

Date of
birth Dec 9 1924

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 6

Number of child of this mother now living, including present birth 3

FULL
NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST

BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

FULL
MAIDEN
NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST

BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 7 40 P M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

M. C. MacKinnon M.D.

Physician

(Physician or midwife)

Address

Shelburne Ida

Filed

Dec 9 1924

Registrar.

Registrar.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

Bingham

Registration District No.

126

Primary Registration District No.

2185

City of

Sterling

(No.)

St.)

Registered No.

48311

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Still born Taggart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male

white

Single

(Write the word.)

6. DATE OF BIRTH

Dec 9

1924

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

George Seamen Taggart

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Charlotte Earl

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. S. Taggart

(Address)

Sterling Ida

15.

Filed

Dec 9

19

24 Mcmentiman

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 9

24

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him alive on

19

and that death occurred on the date stated above, at

7:30

P.M.

The CAUSE OF DEATH* was as follows:

Still birth. 30th weeks of intrauterine gestation. breech presentation.

(Duration)

Yrs.

mos.

ds.

Contributory (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

M. C. Martin

M. D.

Dec 9 24 (Address) Aberdeen Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Aberdeen Ida

Dec 10 1924

20. UNDERTAKER

Friends

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

849-139010-613

County of San JuanCity of Sault Stee

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 127723

No. 171 St. Registration District No. 73 State File No. _____Hospital _____ Primary Registration District No. 2100 Local Registrar's No. 41-9

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Apr 30</u> 192 <u>4</u> (Month) (Day) (Year)
--------------------------	---	-------	--------------------------------	-----------------------------	---

What bactericidal solution was used in eyes? noneNumber of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FULL NAME <u>George E. Grinton</u>	FATHER
RESIDENCE <u>Sault Stee Ida.</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>24</u> (Years)
BIRTHPLACE <u>Burr Lake, Sault</u>	
OCCUPATION <u>Labour</u>	

FULL MAIDEN NAME <u>Flourne Hatters</u>	MOTHER
RESIDENCE <u>Sault Stee Ida.</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>19</u> (Years)
BIRTHPLACE <u>Utah</u>	
OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 3 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Wm J. Grinton

(Physician or midwife)

Address Sault Stee Ida.Filed Dec 2 1924 Wm J. Grinton

Registrar.

Registrar.

10-4113

No.

Итого:

HOW TO SWEET LIFE

(Certificate of no crime without full name of child)

10 x 9 1/2
5 1/2 x 3 1/2

Hybrid is able to travel at 100 km/h.

What particular solution was used in 1961?

murder of child of this mother, including present birth

114
115

RESULTS

NAME
MAYDEN
JUL

RECEIVED

RESIDENCE

ՀԵՐՈՅ

TRAJTA ZDA
YACHTWIB

FOR

ACB 41284
YACHTMAN

30A19HTA86

704.184T 9/8

OPERATION

VOLUNTARIES

1. CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

at 2000 hours I personally verified that I attended the birth of this child, who was born

When there was no attending physician or midwife, then the latter householder etc. should make this return. A midwife is one that neither prescribes nor shows other evidence of the office.

891

20211201

281.

7871290H

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Quinton

RECEIVED

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

No. 370-17th City Idaho Falls St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 47657

Local Registrar's No. 160

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word)

6. DATE OF BIRTH

Nov. 30 1924
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many
8 hrs. or ? min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J. E. Quinton

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Florence E. Walters

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. E. Quinton

(Address)

Idaho Falls

15.

Filed

Dec 1

19

24 Idaho Falls

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 30 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 30 1924 to Nov 30 1924

that I last saw him alive on Idaho Falls 19

and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Still birth - Due to
compression cord in uterus
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. E. Quinton M. D.

12/1 1924 (Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls, Idaho

DATE OF BURIAL

12/2 1924

20. UNDERTAKER

Edmund J. ...

ADDRESS

Idaho Falls

J. E. Quinton

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home,** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH,** state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL,** or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

869-225014315
County of Canyon

City of Caldwell

No. R. # 4 - St.

Hospital

FULL NAME OF CHILD

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED
JAN 12 1924
BUREAU OF CERTIFICATE OF BIRTH

Registration District No. 9 State File No. 127781

Primary Registration District No. 2005 Local Registrar's No. 179

(Certificate of no value without full name of child)

Sex of Child	Female	Twin Triplet or other?		and	Number in order of birth	Legitimate?	Yes	Date of birth	12/25	1924	
									(Month)	(Day)	(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FULL NAME FATHER

Earl Horton

RESIDENCE

Caldwell, Idaho R. # 4

COLOR

White

AGE AT LAST BIRTHDAY 28

(Years)

BIRTHPLACE

Oklahoma

OCCUPATION

Farming

FULL MAIDEN NAME

MOTHER
Grace Lancaster

RESIDENCE

Caldwell, Idaho R. # 4

COLOR

White

AGE AT LAST BIRTHDAY 20

(Years)

BIRTHPLACE

Ill.

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive }
on the date above stated. { Stillborn } at 10 A. M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) E. M. Cole

M. D.

(Physician or midwife)

Address Caldwell, Idaho

Filed Dec. 26-1924 John S. Meyer

Registrar.

Registrar.

(10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33) (34) (35) (36) (37) (38) (39) (40) (41) (42) (43) (44) (45) (46) (47) (48) (49) (50) (51) (52) (53) (54) (55) (56) (57) (58) (59) (60) (61) (62) (63) (64) (65) (66) (67) (68) (69) (70) (71) (72) (73) (74) (75) (76) (77) (78) (79) (80) (81) (82) (83) (84) (85) (86) (87) (88) (89) (90) (91) (92) (93) (94) (95) (96) (97) (98) (99) (100)

PLACE OF BIRTH
 COUNTY OF
 STATE OF
 HOSPITAL
 TITLE NAME OF CHILD

STATE OF
 COUNTY OF
 CITY OF
 CERTIFICATE OF BIRTH

Primary Registration District No. 123456
 Registration District No. 123456
 Date of Birth 12-25-1912
 Sex of Child (M/F)
 Color of Child (M/F)
 Birthplace (M/F)
 Occupation (M/F)

What photographic solution was used in case?
 Number of child of this mother, including present birth
 FATHER
 NAME
 RESIDENCE
 COLOR
 AGE AT LAST BIRTHDAY (Years)
 BIRTHPLACE
 OCCUPATION
 Number of child of this mother now living, including present birth
 MOTHER
 NAME
 RESIDENCE
 COLOR
 AGE AT LAST BIRTHDAY (Years)
 BIRTHPLACE
 OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OF MIDWIFE
 I hereby certify that I attended the birth of this child, who was born on the 25th day of December, 1912, at the residence of the mother.
 (Signature)
 (Physician or midwife)
 Address
 Date of Birth 12-25-1912

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Canyon

City of Caldwell # 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Horton

RECEIVED CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

(No. St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 48035

Local Registrar's No. 12

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Female White (Write the word)

6. DATE OF BIRTH

Dec. 25 1924
(Month) (Day) (Year)

7. AGE

Stillborn

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Caldwell, R. # 4
(State or Country)

10. NAME OF Father Earl Horton

11. BIRTHPLACE OF FATHER Oklahoma
(State or Country)

12. MAIDEN NAME OF MOTHER Grace Lancaster

13. BIRTHPLACE OF MOTHER Ill.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl Horton
(Address) Caldwell, R. # 4

15.

Filed Dec. 27 - 1924 John S. Mezes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 25 1925
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19

that I last saw h. alive on 19 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillbirth at 10 A. M.
result of difficult delivery.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

12-26-1924 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Canyon Hill

12-27 1924

20. UNDERTAKER

C. V. Peckham

ADDRESS

Caldwell, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

RECEIVED

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of CanyonCity of Wilder

JAN 12 1925

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. 946-225014-133 St.Registration District No. 3State File No. 127788

Hospital

Primary Registration District No. 2005 Local Registrar's No. 172

FULL NAME OF CHILD

Lucy Huff

(Certificate of no value without full name of child)

Sex of Child

FemaleTwin
Triplet
or other?

}

and {

Number
in order
of birthLegiti-
mate?yesDate of
birth11-251924

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1Number of child of this mother now living, including present birth 0FULL
NAME

FATHER

Gus Huff

RESIDENCE

Wilder

COLOR

WhiteAGE AT LAST
BIRTHDAY24

(Years)

BIRTHPLACE

Okla.

OCCUPATION

FarmerFULL
MAIDEN
NAME

MOTHER

Mildred Kelley

RESIDENCE

Wilder

COLOR

WhiteAGE AT LAST
BIRTHDAY23

(Years)

BIRTHPLACE

Oreg

OCCUPATION

HW

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 10 30 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

J. S. Gorman

(Physician or midwife)

Address

Caldwell, Ida

Filed

Jan. 7, 1925 John S. Meyer

Registrar.

Registrar.

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE ACT OF MARCH 3, 1907, ONLY. IT IS NOT VALID FOR THE PURPOSES OF THE ACT OF MARCH 3, 1907, ONLY. IT IS NOT VALID FOR THE PURPOSES OF THE ACT OF MARCH 3, 1907, ONLY.

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
DIVISION OF RECORDS AND STATISTICS
BUREAU OF VITAL STATISTICS
DIVISION OF RECORDS AND STATISTICS

County of San Diego
City of San Diego
Registration District No. 12
Primary Registration District No. 12 Local Registration District No. 12

Birth Date of Child 12-12-1912
Certificate of no living without full name of child
Sex Male Race White Color White
Height 50 Weight 10 Length 18
Circumference of head 18 Circumference of chest 18 Circumference of arm 10

Number of children ever born 1 Number of children living 1
Number of children ever born 1 Number of children living 1

FATHER	MOTHER
Full Name <u>John J. Smith</u>	Full Name <u>John J. Smith</u>
Residence <u>San Diego</u>	Residence <u>San Diego</u>
Color <u>White</u>	Color <u>White</u>
Age at Birth <u>35</u>	Age at Birth <u>35</u>
Birthplace <u>San Diego</u>	Birthplace <u>San Diego</u>
Occupation <u>Teacher</u>	Occupation <u>Teacher</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of this child, who was born at San Diego on the 12 day of December, 1912.
Signature John J. Smith
(Physician or midwife)
Address San Diego
Filed 12-12-1912

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CLAIMS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. EXAM-
ment of OCCUPATION is very important. See instructions on back of certificate.

12 1/2 M. 7-24-11

PECO

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 48033

Registered No. 11

If death occurred in a hospital, in-
stitution or camp give its NAME
instead of street and number.

PLACE OF DEATH.
County of Canyon
City of Hilder

Registration District No. 3
Primary Registration District No. 2004
(No. , St.)

If death occurs away from us-
ual residence, give facts called
for under special information.

2. FULL NAME

Huff

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Female White (Write the word.)

6. DATE OF BIRTH

11 - 25 1924
(Month) (Day) (Year)

7. AGE

Shilborn -
yrs. mos. ds. IF LESS than 1 day
how many hrs. or
min?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of industry
business or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country) Hilder

10. NAME OF
FATHER

Guss Huff -

11. BIRTHPLACE
OF FATHER

(State or Country) Okla -

12. MAIDEN NAME
OF MOTHER

Mildred Alley

13. BIRTHPLACE
OF MOTHER

(State or Country) Ariz

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. D. Foster
(Address) Coconino Co. Ariz

15.

Filed Jan. 7 - 1925 - John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

11 - 25 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
11 - 25 1924, to 11 - 25 1924

that I last saw h. Still born 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Albuminuria -

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. D. Foster M. D.

Jan 7 1925 (Address) Coconino Co. Ariz

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hilder Cemetery 11-26-1924
Saffman Ranch

20. UNDERTAKER ADDRESS

J. S. Rogers Hilder Idaho
Hilder & Sons

The above information received from
Dr. J. D. Foster - John S. Meyer.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital)," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

393-103 016962

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Cassia

City of Burley

No. _____ St. _____

Hospital _____

Registration District No. 117

Primary Registration District No. 2196

File No. _____

Registered No. 2996

127835

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and <u> </u>	Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>Dec. 3</u> 19 <u>24</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

What bacteriocidal solution was used in eyes? None

Number of child of this mother, including present birth. 15 Number of child of this mother now living, including present birth. 12

FATHER
FULL NAME A.C. Tilley
RESIDENCE Burley, Ida.
COLOR White AGE AT LAST BIRTHDAY 39 (Years)
BIRTHPLACE Utah
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Ethel Robinson
RESIDENCE Whitex Burley, Ida.
COLOR White AGE AT LAST BIRTHDAY 36 (Years)
BIRTHPLACE Utah
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 4 P. M.
on the date above stated. (Born alive or stillborn)

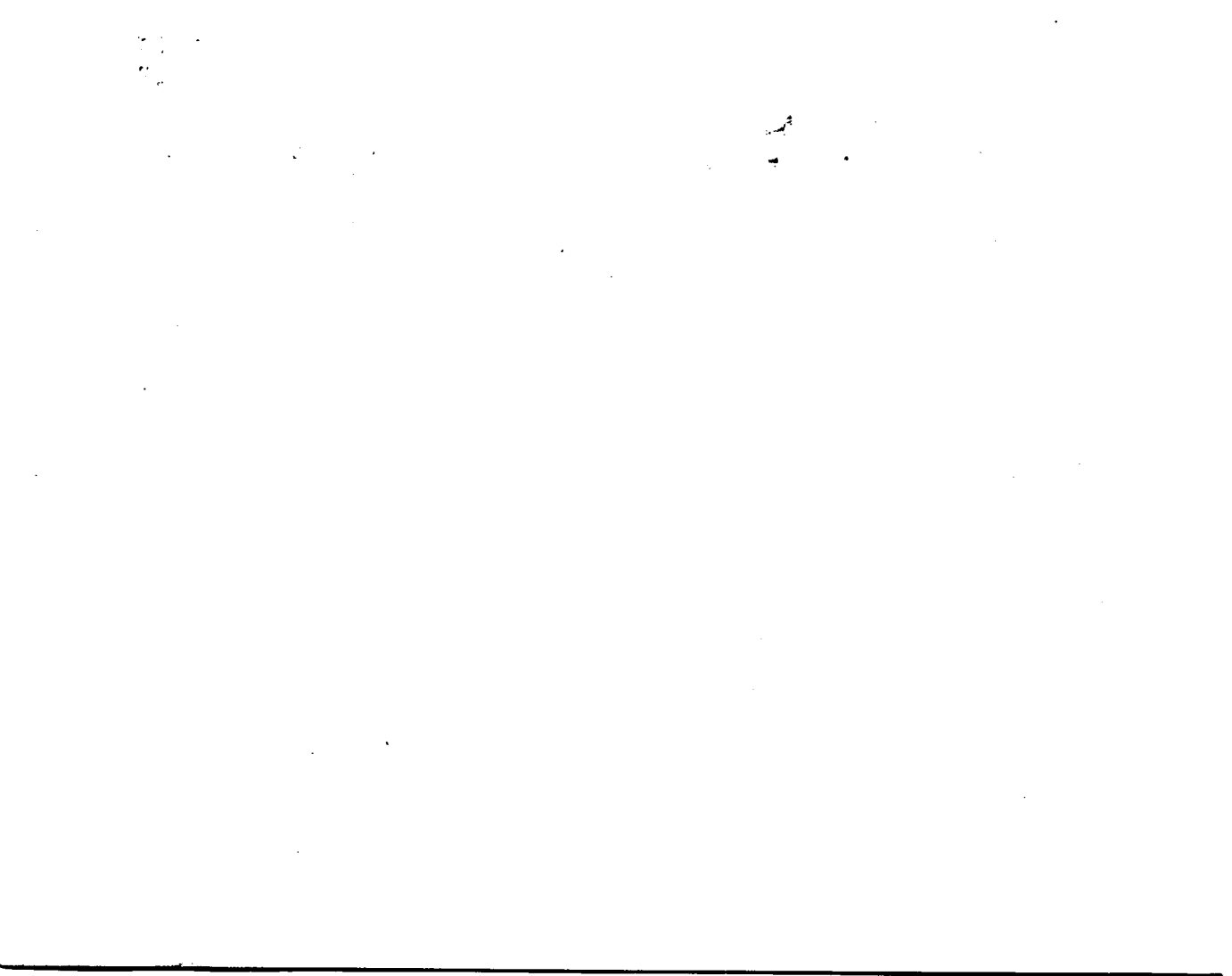
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. J. C. Patterson
Physician
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address Burley, Idaho.
Filed 12-13- 1924 Dr. J. C. Patterson
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Cassia Registration District No. 117
City of Burley Registration District No. 2196
(No. _____ St.)

State File No. 48337
Local Registrar's No. 754

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Stillborn Tilley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word)

6. DATE OF BIRTH

Dec. 3 1924
(Month) (Day) (Year)

7. AGE

Yrs. # Mos. # ds.

IF LESS than 1
day how many
hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Burley, Ida.

10. NAME OF FATHER

A. C. Tilley

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Ethel Robinson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. C. Tilley

(Address)

Burley, Ida.

15.

Filed

12-31924Hugh Patterson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 3 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
..... 19..... to 19.....

that I last saw him alive on 19.....
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Stillborn, Doctor dead for about 2 weeks cause unknown.

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. C. Patterson M. D.12-4 19-24 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days, State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Burley, Ida.

DATE OF BURIAL

12-3 1924

20. UNDERTAKER

None

ADDRESS

✓

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

RECEIVED

JAN 3 1925

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S
127964

County of _____

City of _____

No. _____ St. _____

Registration District No. _____

File No. _____

Hospital _____

Primary Registration District No. _____

Registered No. _____

FULL NAME OF CHILD

Mary Elizabeth Price

(Certificate of no value without full name of child.)

Sex of Child

Female

Twin
Triplet
or other?

and

Number
in order
of birth

1st

Legiti-
mate?

yes

Date of
birth

Nov 13

1924

(To be answered only in event of plural births)

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

No. Sterilized

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FULL
NAME

Oral Price

FATHER

FULL
MAIDEN
NAME

MOTHER

Mrs. M. M. M.

RESIDENCE

Hagerman

RESIDENCE

Hagerman

COLOR

White

AGE AT LAST
BIRTHDAY

00

(Years)

COLOR

W

AGE AT LAST
BIRTHDAY

20

(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Idaho

OCCUPATION

Farmer

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.

(Born alive or stillborn)

9 P

M.

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

H. E. Lamm

(Physician or midwife)

Give names added from a supplemental report.

Address

Filed

1925

H. E. Lamm

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

HEALTH

43072

NAME		LAST		FIRST		MIDDLE	
DATE OF BIRTH		MONTH		DAY		YEAR	
SEX		MALE		FEMALE			
RACE		WHITE		BLACK		OTHER	
EDUCATION		HIGH SCHOOL		COLLEGE		POSTGRADUATE	
OCCUPATION		FARMER		LABORER		PROFESSIONAL	
RESIDENCE		CITY		STATE		COUNTRY	
MARRIAGE		MARRIED		SINGLE		DIVORCED	
CHILDREN		ONE		TWO		THREE	
RELIGION		CATHOLIC		PROTESTANT		OTHER	
MILITARY SERVICE		YES		NO			
REMARKS							

THIS CARD IS TO BE FILLED OUT BY THE INDIVIDUAL OR BY SOMEONE KNOWING HIM OR HER WELL. IT IS NOT TO BE FILLED OUT BY A PHYSICIAN OR OTHER MEDICAL PERSONNEL. IT IS TO BE FILLED OUT BY THE INDIVIDUAL OR BY SOMEONE KNOWING HIM OR HER WELL. IT IS NOT TO BE FILLED OUT BY A PHYSICIAN OR OTHER MEDICAL PERSONNEL.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho JAN 20 1925

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

Place of Birth	(CITY <u>Hagerman</u>	FILE NO. <u>127964</u>
	(ST. <u>Idaho</u>	DATE OF BIRTH <u>Nov. 13, 1924</u>
	(COUNTY <u>Boise</u>	SEX OF CHILD <u>Female</u>
FATHER <u>Oral H. Price</u>		MOTHER <u>Ida La Rue Moore</u> (MAIDEN NAME)

I HEREBY CERTIFY that the child herein described has been named:

Mary Elizabeth Price

RECEIVED
JAN 27 1925
BUREAU OF VITAL
STATISTICS

Mrs. Oral H. Price
Signature of Father or Mother.

DEPARTMENT OF PUBLIC HEALTH

Re: [Name], [Address]

Dear Sir:

The name of your baby was not filed in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS

CITY

State

DATE OF BIRTH

FATHER

(MOTHER'S NAME)

I HEREBY CERTIFY that the child [Name] was born [Date]

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

45 321 026 238
PLACE OF BIRTH

RECEIVED
JAN 2 1925
BUREAU OF VITAL STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S128017

County of Jafferson
City of Rigby
No. 98 St. 2176 Registration District No. 98 State File No. 458
Hospital not named Primary Registration District No. 2176 Local Registrar's No. 458
FULL NAME OF CHILD not named
(Certificate of no value without full name of child.)

Sex of Child <u>Girl</u>	Twin <u>Yes</u> and <u>Number 2nd</u> Triplet or other? <u>Yes</u> and <u>in order of birth</u> (To be answered only in event of plural births)	Legitimate? <u>Yes</u>	Date of birth <u>Oct 11</u> , 192 <u>4</u> (Month) (Day) (Year)
--------------------------	---	------------------------	--

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth <u>3</u> Number of child of this mother now living, including present birth <u>2</u>	
FULL NAME <u>A D Meehan</u>	FULL MAIDEN NAME <u>Caroline Schless</u>
RESIDENCE <u>Rigby Idaho</u>	RESIDENCE <u>Idaho</u>
COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>22</u> (Years)	COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>22</u> (Years)
BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Idaho</u>
OCCUPATION <u>farmer</u>	OCCUPATION <u>housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 9:30 a.m. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Sam T. Fried
Physician
(Physician or midwife)

Give names added from a supplemental report.
_____, 192____

Address Rigby Idaho
Filed 12-10-1924 Rayn Fisher
Registrar.

(over)

RENEWED TWENTY-THREE (23) YEARS AGO AT CHICAGO, ILL. APPROVED BY THE CHIEF OF BUREAU OF VITAL STATISTICS
 I have examined the original and certified a true and correct copy of the same to the proper authorities for their use.

STATE OF ILLINOIS
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

the birth of first child the placenta detached and the placenta child pushed forward & covered

NAME: *John* RESIDENCE: *Chicago*
 MOTHER: *John* FULL NAME: *John*
 BIRTHDAY: *1900* AGE AT LAST BIRTHDAY: *1900*
 BIRTHPLACE: *Chicago* COLOR: *White*
 OCCUPATION: *None* BIRTHPLACE: *Chicago*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born on the date above stated.
 (Signature) *John*
 (Physician or midwife)
 Address: *Chicago*
 Registered: *John*

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A--25 M. 1-19.

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No.

BUREAU OF VITAL STATISTICS

BUREAU OF VITAL STATISTICS

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

19... to 19...
that I last saw h... alive on 19...
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Premature separation
of the placenta
(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) Sam F. Price M. D.

10-12-1924 (Address) Kirie

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

15-3
1924

853-120-07-796
PLACE OF BIRTH

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
JAN 10 1925
CERTIFICATE OF BIRTH 128120

County of Jerome
City of Hazelton
No. 23 St. Registration District No. 23 State File No. 1017
Hospital 1017 Primary Registration District No. 2017 Local Registrar's No. 1017
FULL NAME OF CHILD Frank Helms Stillborn
(Certificate of no value without full name of child)

Sex of Child M Twin Triplet or other? and Number in order of birth 1 Legitimate? yes Date of birth Sept 20 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? no

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 6

FATHER		MOTHER	
FULL NAME	<u>Joseph Helms</u>	FULL MAIDEN NAME	<u>Myrtle Belle Grooms</u>
RESIDENCE	<u>Hazelton Idaho</u>	RESIDENCE	<u>Hazelton</u>
COLOR	<u>wh</u>	COLOR	<u>wh</u>
AGE AT LAST BIRTHDAY	<u>36</u> (Years)	AGE AT LAST BIRTHDAY	<u>35</u> (Years)
BIRTHPLACE	<u>Calo</u>	BIRTHPLACE	<u>Okla</u>
OCCUPATION	<u>Laborer</u>	OCCUPATION	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 4 30 P M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E L Berry MD

(Physician or midwife)

Give names added from a supplemental report.
_____, 1924
Registrar.

Address Hazelton Idaho
Filed E. D. P. M. D. 1924
Jan 6 - 1925
Registrar.



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jerome Registration District No. 23
City of Hazelton Primary Registration District No. 1017-2017
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank HelmsFile No. 48106

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH

Sept 20 1924
(Month) (Day) (Year)

7. AGE

21 Yrs. 20 Mos. 20 ds. IF LESS than 1 day
how many 20 hrs.
or 20 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Hazelton Ida

10. NAME OF FATHER

Samuel Helms

11. BIRTHPLACE OF FATHER

(State or Country) Calo

12. MAIDEN NAME OF MOTHER

Myrtle Belle Gross

13. BIRTHPLACE OF MOTHER

(State or Country) Okla

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samuel Helms, Reg. S. R. B. Bureau
(Address) Hazelton Ida

15. Sept 21 1925 F. D. Piper M.D.
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 20 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Stillborn 1924
that I last saw h. alive on 19
and that death occurred on the date stated above, at 4:30 M.

The CAUSE OF DEATH* was as follows:

Premature birth
Respiration due to knot in
uterine cord

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ mos. _____ ds.

(Signed)

E. L. Berry M. D.
9-21-24 (Address) Hazelton

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Hazelton Cemetery

DATE OF BURIAL

9-21-24

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

RECEIVED

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of JeromeCity of JeromeNo. 168 129 027 957

St.

BUREAU OF VITAL

STATISTICS

Registration District No. 23CERTIFICATE OF BIRTH 128135State File No. 1017

Hospital

Primary Registration District No. 2017

Local Registrar's No.

FULL NAME OF CHILD unnamed Johnson

(Certificate of no value without full name of child)

Sex of Child mTwin
Triplet
or other?and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate? yesDate of
birth Dec 27 1924

(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FULL
NAME

FATHER

E. B. Johnson

RESIDENCE

Jerome

COLOR

whiteAGE AT LAST
BIRTHDAY 42

(Years)

BIRTHPLACE

Kentucky

OCCUPATION

FarmerFULL
MAIDEN
NAME

MOTHER

Lucie L. Ingraham

RESIDENCE

Jerome

COLOR

whiteAGE AT LAST
BIRTHDAY 36

(Years)

BIRTHPLACE

Kentucky

OCCUPATION

Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { born alive } at 6 a. N. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

E. D. Piper M.D.

(Physician or midwife)

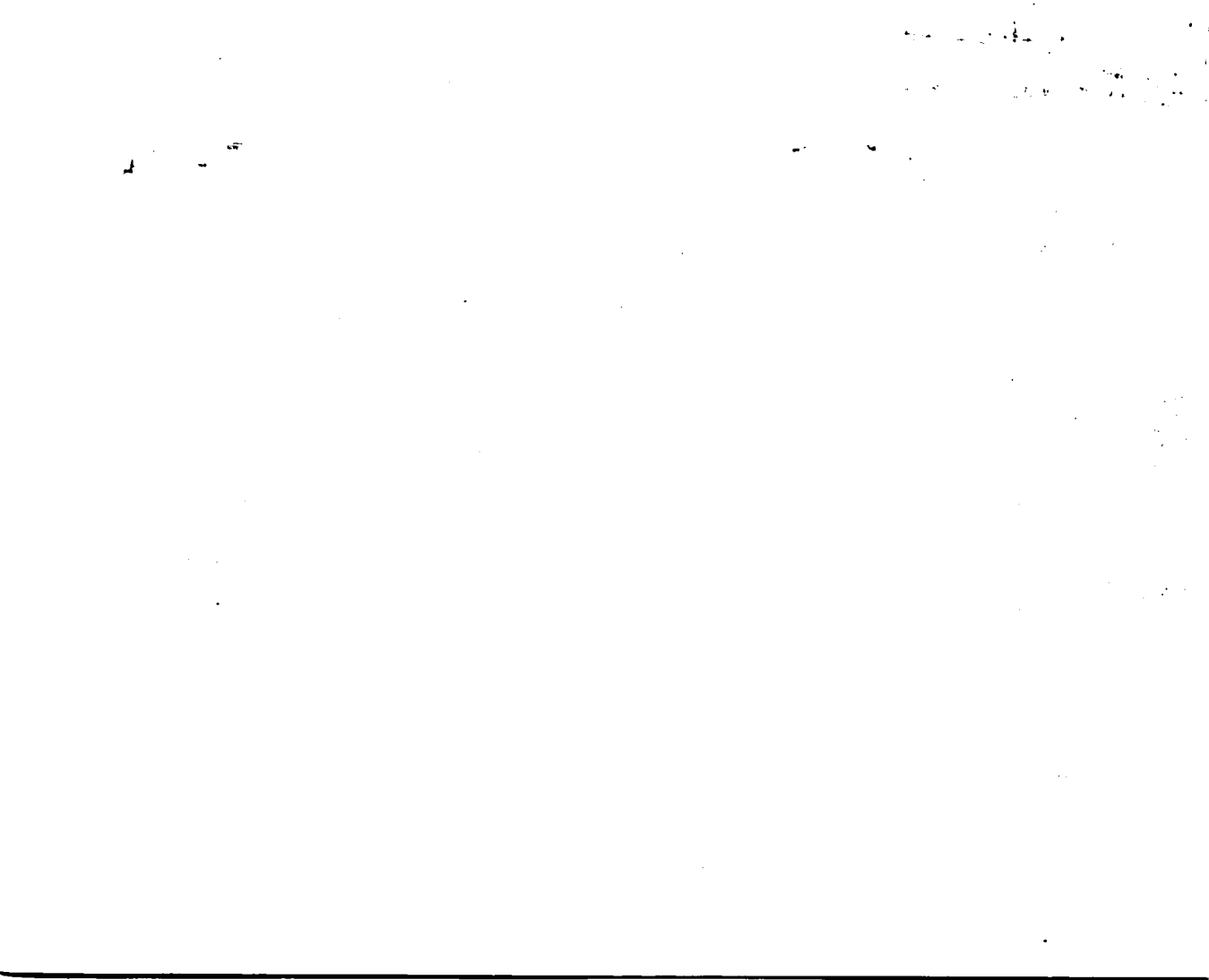
Address

Filed

Jan 6 1925 E. D. Piper M.D.

Registrar.

Registrar.



1. PLACE OF DEATH

County of Jerome
City of Jerome

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED CERTIFICATE OF DEATH

Registration District No. 23Primary Registration District No. 1017-2017(No. Johnson St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 48112

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Infant
(Write the word.)

6. DATE OF BIRTH

Dec 27 1924
(Month) (Day) (Year)

7. AGE

Yrs. 0 Mos. 0 ds.IF LESS than 1 day
how many 0 hrs.
or 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Jerome Idaho

10. NAME OF FATHER

E. P. Johnson

11. BIRTHPLACE OF FATHER

(State or Country) Kentucky

12. MAIDEN NAME OF MOTHER

Lucie L. Ingraham

13. BIRTHPLACE OF MOTHER

(State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. P. Johnson(Address) Jerome15. Filed Dec 27 1924 E. D. Piper
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 27 1924
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1924 to Dec 27 1924that I last saw him 4 alive on Dec 27 1924and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

I still born(Duration) Yrs. 0 mos. 0 ds.
Contributory (Secondary) Mother's haemic and with eclampsia acute(Duration) yrs. 0 mos. 0 ds.
(Signed) E. D. Piper M. D.Dec 27 1924 (Address) Jerome

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 0 mos. 0 days. In the State yrs. 0 mos. 0 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jerome CemeteryDec 27 1924

20. UNDERTAKER

ADDRESS

D. G. L. HarrisonJerome Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

DEC 13 1924

DEPARTMENT OF PUBLIC WELFARE

S

County of Madison

BUREAU OF

BUREAU OF VITAL STATISTICS

City of Reuburg

STATION

CERTIFICATE OF BIRTH

No. 231103.033.29

St. Registration District No. 100

State File No.

128268

Hospital

Primary Registration District No. 2178

Local Registrar's No. 968

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child Male

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate? Yes

Date of
birth Nov. 3

1924

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes? —

Number of child of this mother, including present birth 1

Number of child of this mother now living, including present birth 1

FATHER
FULL NAME

Albert Blackburn

MOTHER
FULL MAIDEN NAME

Josephine Barrett

RESIDENCE

Reuburg

RESIDENCE

Reuburg

COLOR W

AGE AT LAST

BIRTHDAY 20
(Years)

COLOR W

AGE AT LAST

BIRTHDAY 19
(Years)

BIRTHPLACE

Ida

BIRTHPLACE

Ida

OCCUPATION

Printer

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 3:00 P M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) H. B. Rigby

(Physician or midwife)

Address

Filed 177

1924

Registrar.

Registrar.

THIS IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD AS KEPT IN THE OFFICE OF THE REGISTRAR OF BIRTHS AND DEATHS, DISTRICT OF COLUMBIA, D.C.

Registrar.
Filed
Address

(Physician or midwife)

(Signature)

When there was no attending physician or midwife, then the father, householder, or other person who was present at the birth, should make this return. A stillborn child is one that neither breathes nor shows other evidence of life at birth.

(Give names added from a supplemental report.)

on the date above stated.

I hereby certify that I attended the birth of this child, who was born at

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

OCCUPATION BIRTHPLACE AGE AT LAST BIRTHDAY (1 year) COLOR AGE AT LAST BIRTHDAY (1 year) RESIDENCE

FATHER FULL NAME RESIDENCE

MOTHER FULL NAME RESIDENCE

Number of child of this mother, including present birth

Number of child of this mother, not including present birth

NAME FULL NAME

FATHER

MOTHER

What bactericidal solution was used in eyes?

Child

Sex of

or other

and

of birth

in order

Testis

Testicle

(To be answered only in case of a stillbirth)

FULL NAME OF CHILD

Hospital

Primary No. (When in the No. 1000 Hospital No. 1000)

Secondary No. (When in the No. 1000 Hospital No. 1000)

(Certificate of a child's name and full name of child)

City of

County of

State of

Registration District No.

13828

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of MinnesotaCity of PO PaulNo. 394122-034-393St. Registration District No. 19 State File No. 128355Hospital _____ Primary Registration District No. 128355 Local Registrar's No. 141FULL NAME OF CHILD unnamed stillborn

(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin Triplet or other? _____ } and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Nov. 22 1924</u> (Month) (Day) (Year)
--------------------------	---	------------------------	---

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 3

FATHER

FULL NAME Emil C. Crumroy

RESIDENCE Paul, Idaho

COLOR white AGE AT LAST BIRTHDAY 37 (Years)

BIRTHPLACE Iowa

OCCUPATION Farmer

MOTHER

FULL MAIDEN NAME Edna Lee Titus

RESIDENCE Paul, Idaho

COLOR white AGE AT LAST BIRTHDAY 32 (Years)

BIRTHPLACE Iowa

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn { born alive } at 5:00 A- M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Leona Trozier, M.D.

(Physician or midwife)

Address Rupert, IdahoFiled Dec 4 1924 E. P. Elmore

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

3

286107 035 236

PLACE OF BIRTH

JAN 9 1924

STATE OF IDAHO

Form V. S. No. 11-G-25a-33-17

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

County of *Key Perce*City of *Caldwell*Registration District No. *128*File No. *128382*

No.St.

Primary Registration District No. *Caldwell*Registered No. *Nearby*

Hospital

FULL NAME OF CHILD *Robert Stanley Shoemaker*

Sex of Child

*Male*Twin
Triplet
or other?and (Number
in order
of birth)

(To be answered only in event of plural births)

Legiti-
mate?*yes*Date of
Birth*10**7**1924*

(Month) (Day) (Year)

FULL
NAME

FATHER

*Samuel Shoemaker*FULL
MAIDEN
NAME

MOTHER

Bertha Scott

RESIDENCE

Caldwell Idaho

RESIDENCE

Caldwell Idaho

COLOR

*White*AGE AT LAST
BIRTHDAY*41*

(Years)

COLOR

*White*AGE AT LAST
BIRTHDAY*37*

(Years)

BIRTHPLACE

Washington

BIRTHPLACE

Minnesota

OCCUPATION

Laborer

OCCUPATION

*Housewife*Number of child of this mother, including present birth... *14*Number of children of this mother now living, including present birth... *14*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was.....
on the date above stated.*Stillborn*..... at *9:10 P.* M.
(Born alive or stillborn)*When there was no attending physician or
midwife then the father, householder, etc., should
make this return. A stillborn child is one that
neither breathes nor shows other evidence of life
after birth.

(Signature)

George Gagnard
Physician
(Physician or midwife)

Given names added from a supplemental report.

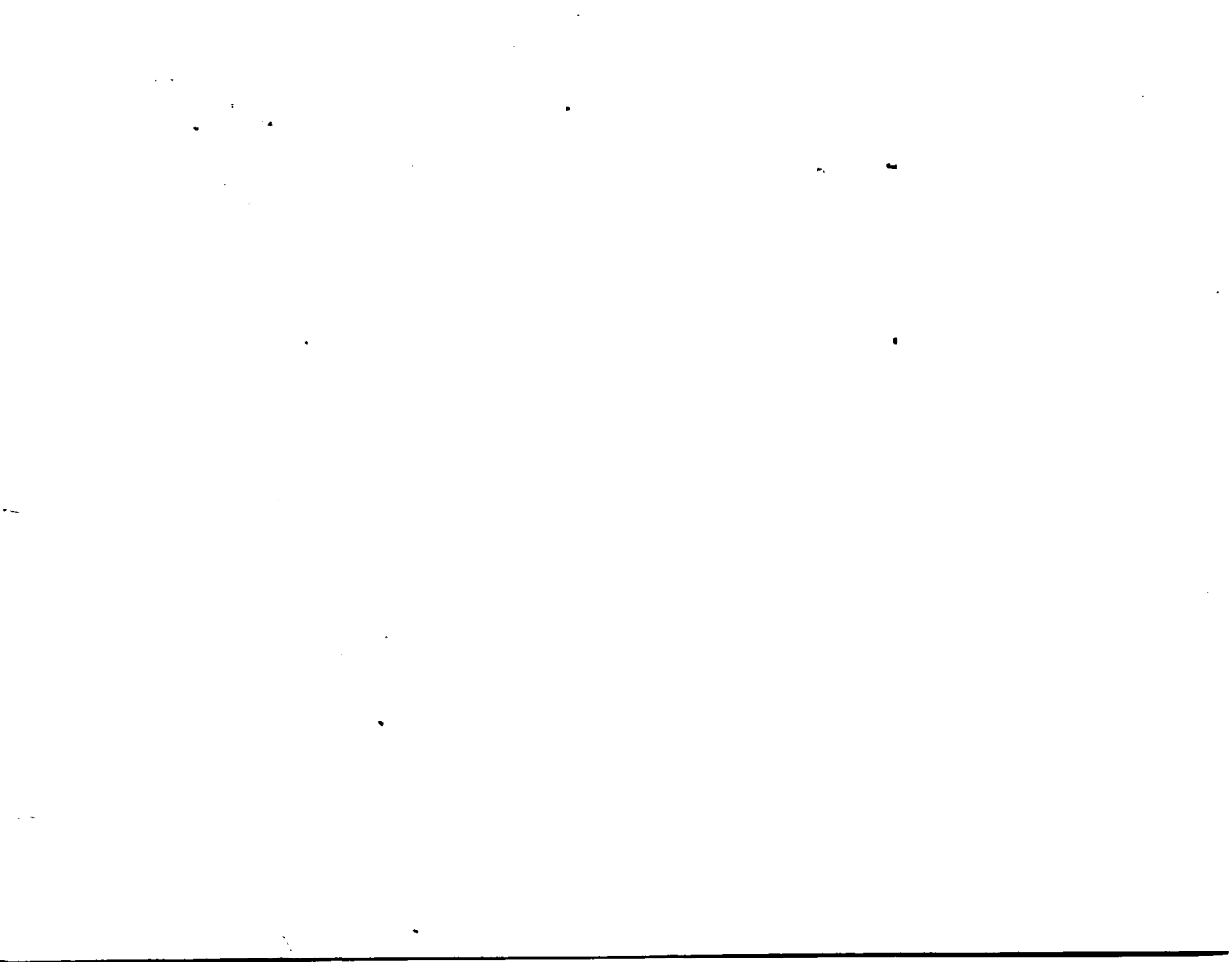
Address

Caldwell Idaho

Filed

Oct 24 *George Gagnard*
Registrar

Registrar



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *RECEIVED*
Registration District No. *128*
County of *Nut River* Primary Registration District No. *Caldwell*
City of *Caldwell* (No. *1*) (City of *Idaho*)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME *Robert Stanley Shoemaker*
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)
6. DATE OF BIRTH *Oct 7 1924*
(Month) (Day) (Year)
7. AGE *—* IF LESS than 1 day how many hrs. or min.?
Yrs. Mos. ds.
8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).
9. BIRTHPLACE *Idaho*
(State or Country)
10. NAME OF FATHER *Samuel S. Shoemaker*
11. BIRTHPLACE OF FATHER *Washington*
(State or Country)
12. MAIDEN NAME OF MOTHER *Bertha Scott*
13. BIRTHPLACE OF MOTHER *Minnesota*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Samuel S. Shoemaker*
(Address) *Caldwell, Idaho*
15. Filed *Oct 24* *George Gaignard*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Oct 7 1924*
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from *—* 19 *—* to *—* 19 *—*
that I last saw him alive on *—* 19 *—*
and that death occurred on the date stated above, at *—* M.
The CAUSE OF DEATH was as follows:
Stillbirth
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) *George Gaignard* M. D.
Oct 24 (Address) *Caldwell Idaho*
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence
19. PLACE OF BURIAL OR REMOVAL *Clarkson Wm* DATE OF BURIAL *Oct 8 1924*
20. UNDERTAKER *H.R. Merchant* ADDRESS *Clarkson Wm*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

819-108 038 -214

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

S128452

County of _____

JAN 20 1925

CERTIFICATE OF BIRTH

City of _____

BUREAU OF VITAL

Registration District No. 4

File No. ~~128282~~

No. _____ St. _____

Primary Registration District No. 1008 Registered No. 94

Hospital _____

FULL NAME OF CHILD _____

Sex of
Child

Male

Twin
Triplet
or other?

and

Number
in order
of birthLegiti
mate?

yes

Date of
Birth

Dec 8

1924

(Month)

(Day)

(Year)

FULL
NAME

C. S. Hart-

FATHER

FULL
MAIDEN
NAME

Alice Badger

MOTHER

RESIDENCE

Payette Ida -

RESIDENCE

Payette Ida -

COLOR

White

AGE AT LAST
BIRTHDAY

29

(Years)

COLOR

White

AGE AT LAST
BIRTHDAY

29

(Years)

BIRTHPLACE

Idaho -

BIRTHPLACE

Idaho

OCCUPATION

Merchant

OCCUPATION

Housewife

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____
on the date above stated.

Stillborn

at 3 P. M.

(Born alive or stillborn)

*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

J. C. Woodward, M.D.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Payette Idaho

Filed

Dec 31 1924 J. C. Woodward

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Payette
 City of Fruitland
754-104038 994
 No. _____ St. _____

RECEIVED

CERTIFICATE OF BIRTH

Registration District No. 51
 Primary Registration District No. 2130

File No. 28460
128200
 Registered No. 17

Hospital _____

Full Name of Child _____

SEX OF CHILD <u>Male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	Number and in order of birth _____	Legitimate? <u>yes</u>	DATE OF BIRTH <u>Nov 4 24</u> (Month) (Day) (Year)
FATHER			MOTHER	
FULL NAME <u>Henry Peutz</u>			FULL MAIDEN NAME <u>Amanda Zimmermann</u>	
RESIDENCE <u>Fruitland Idaho</u>			RESIDENCE <u>Fruitland Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>52</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)	
BIRTHPLACE <u>Germany</u>			BIRTHPLACE <u>Germany</u>	
OCCUPATION <u>Rancher</u>			OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth. 2 Number of children of this mother now living, including present birth. 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at _____ M.
 on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) M. J. Keese M.D.

(Physician or midwife)

Given names added from a supplemental report

Address Ontario OregonFiled 12-9-1924 Mrs Wm J. D. Osborn

Registrar

Registrar

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

REVENUE RESERVED FOR BINDING



CERTIFICATE OF BIRTH

2

PLACE OF BIRTH

County of

DATE OF BIRTH

SEX

AGE

HEIGHT

WEIGHT

EDUCATION

RELIGION

INDUSTRY

RESIDENCE

DATE OF DEATH

CAUSE OF DEATH

RECEIVED

1. PLACE OF DEATH

County of *Payette*
City of *Boise*Registration District No. *51*Registration District No. *2130*
(No. STATISTICS) St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Penk*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *48211*Registered No. *4*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6. DATE OF BIRTH

Nov 4 1924
(Month) (Day) (Year)

7. AGE

*Stillborn*IF LESS than 1 day
how many.....hrs.
or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)*See father*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Henry Penk

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

*Ernesta Zimmerman**Germany*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Henry Penk
Boise

15.

Filed *11/7* 192*4**Wm. D. Snyder*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 4 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 4 1924 to *Nov 4 1924*that I last saw him alive on *Nov 4 1924*and that death occurred on the date stated above, at *6 AM*.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration)Yrs.....mos.....ds.

Contributory
(Secondary)

(Duration)yrs.....mos.....ds.

(Signed) *W. D. Mess* M. D.*11/5 1924* (Address) *Boise, Ore.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Ida 19.....

20. UNDERTAKER

ADDRESS

Roberts Funeral and Payette Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

864 729 242 713
PLACE OF BIRTH

STATE OF MARYLAND
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED
1925
CERTIFICATE OF BIRTH

Form V. S. No. 11--20m-7-26-19

128568

S

128398

County of T. F.City of Buhl

No. _____ St. _____

Registration District No. 39

File No. _____

Hospital _____

Primary Registration District No. 2087

Registered No. _____

FULL NAME OF CHILD Born deadSex of Child MaleTwin
Triplet
or other?

and

Number
in order
of birthLegiti-
mate? YesDate of
Birth

(Month)

(Day)

(Year)

FULL
NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

FULL
MAIDEN
NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born at 2 P. M.
on the date above stated. (Born alive or Stillborn)

(Signature) D. E. Jennings

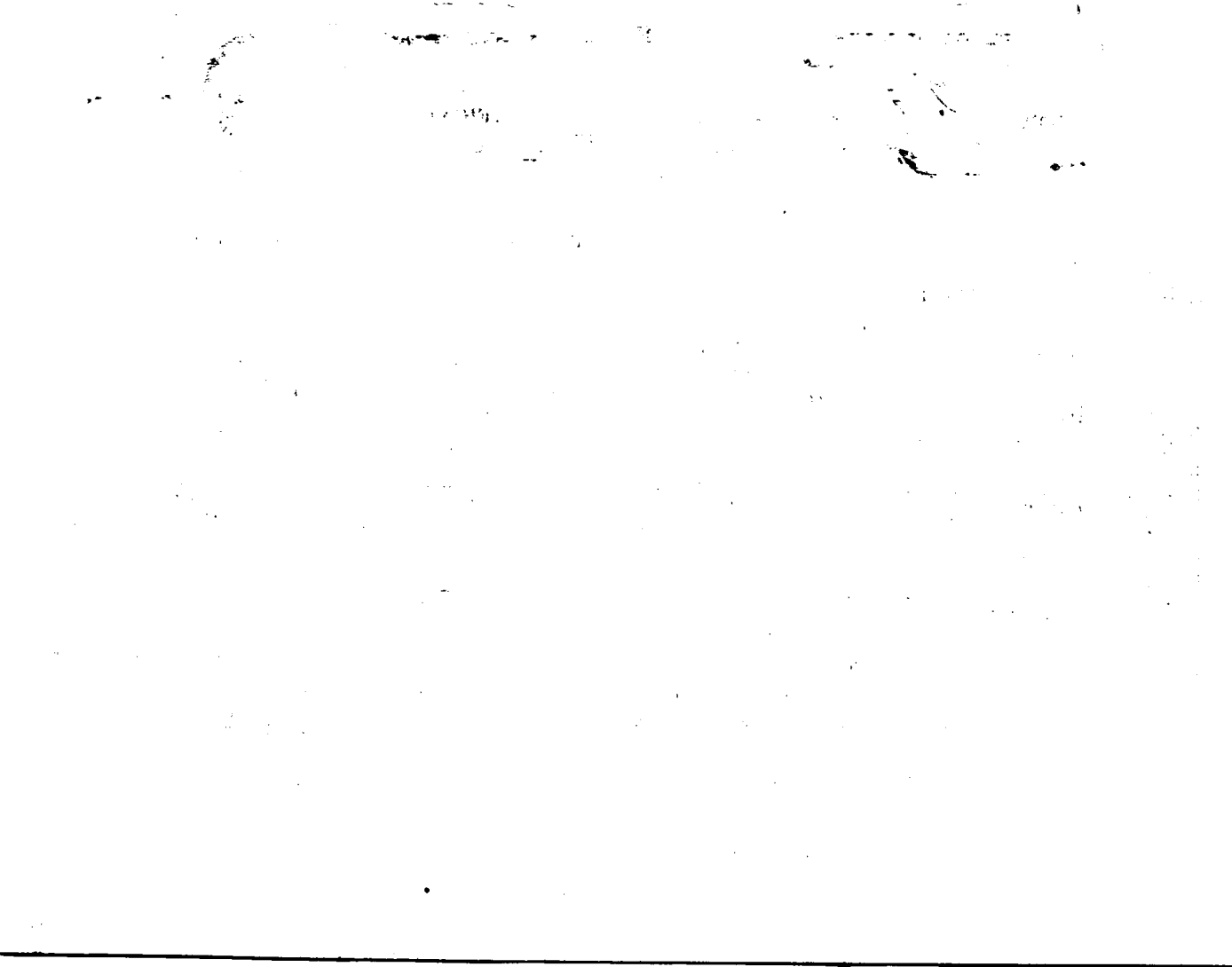
(Physician or midwife)

Given names added from a supplemental report.

19

Address BuhlFiled DEC 31 1924Registrar. J. H. Murphy

Registrar.



STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho JAN 20 1925

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * * *

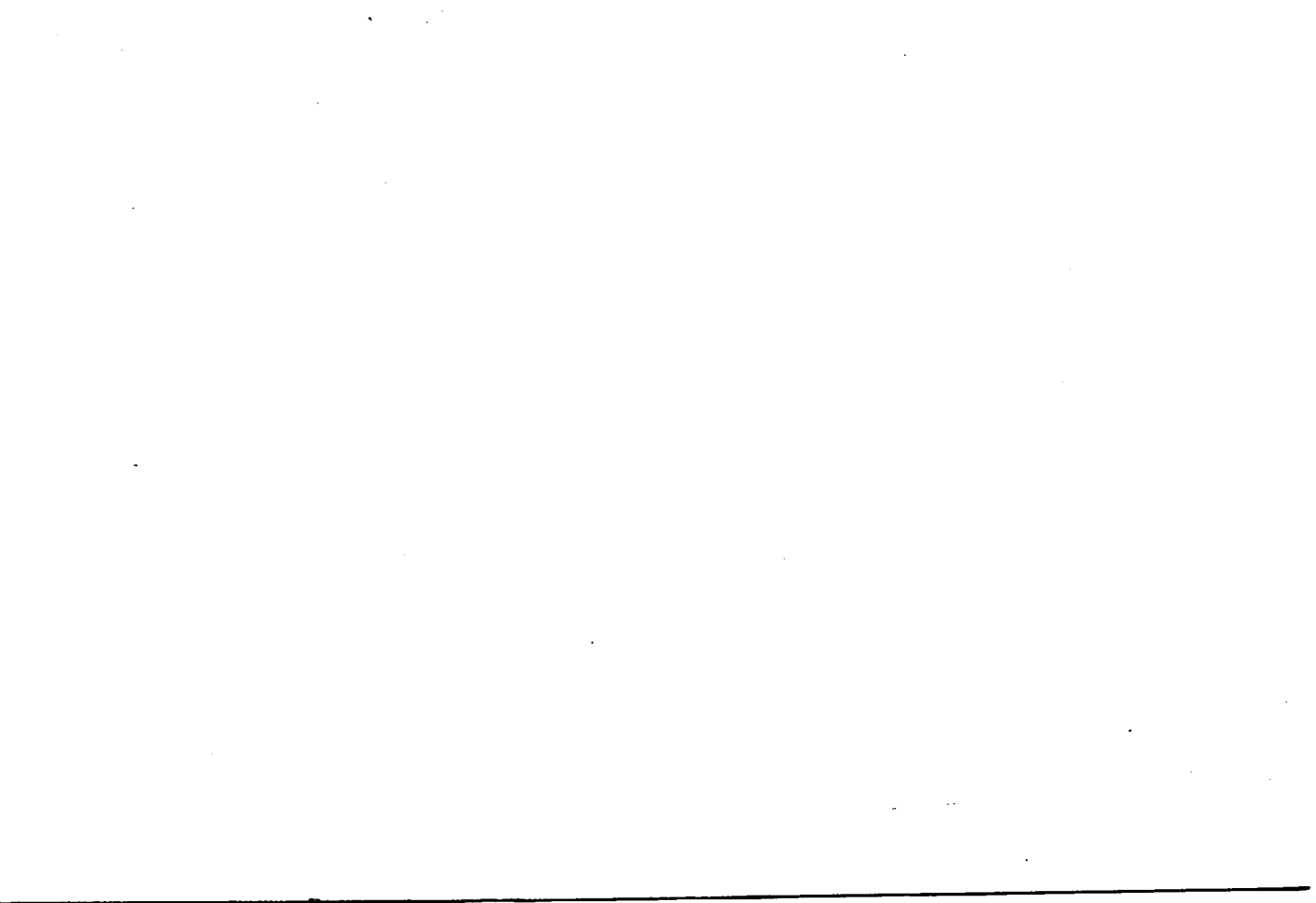
Place of Birth	(CITY <u>Buhl</u>	FILE NO. <u>128568</u>
	(ST. <u></u>	DATE OF BIRTH <u>Dec 29 1924</u>
	(COUNTY <u>Travis Falls</u>	SEX OF CHILD <u>Male</u>
FATHER <u>Edwin F Young</u>		MOTHER <u>Riba Patten</u> (MAIDEN NAME)

I HEREBY CERTIFY that the child herein described has been named:

RECEIVED
FEB 3 1925
REAU OF VITAL
STATISTICS

by was born dead & not named.

Mr. & Mrs. Edwin F Young
Signature of Father or Mother



FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Lumi Tessa Registration District No. 59
City of Buhl Primary Registration District No. 2087
(No. _____ St.)If death occurs away from
usual residence, give facts
called for under special in-
formation.

2. FULL NAME

Baby YoungState File No. 48276
Local Registrar's No. _____If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word)

6. DATE OF BIRTH

Dec 29 1924
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.IF LESS than 1
day how many
☒ hrs. or
☒ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer)9. BIRTHPLACE
(State or Country)Buhl Ida10. NAME OF
FatherEdw. Young11. BIRTHPLACE
OF FATHER

(State or Country)

Kansas12. MAIDEN NAME
OF MOTHERReba Patton13. BIRTHPLACE
OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Edw. Young
Buhl Ida

15.

Filed

Dec 301924J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12 - 29 - 1924
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
12-29-1924 to 12-29-1924,
that I last saw him alive on 12-29-1924,
and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Geo. Jennings M. D.12-29-24(Address) Buhl, Ida*State the Disease Causing Death; or in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place _____ In the
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Buhl Idaho

DATE OF BURIAL

Dec. 30 1924

20. UNDERTAKER

J. Johnson

ADDRESS

Buhl Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation > months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

128610 S

128440

County of WashingtonCity of SpencerNo. 731-210044-556Registration District No. 6State File No. 93

Hospital

Primary Registration District No. 2114Local Registrar's No. 93

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin Triplet or other? <u>no</u>	and Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Nov 10</u> 192 <u>4</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes? ✓Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FULL NAME <u>Clinton Glasscock</u>	FATHER	FULL MAIDEN NAME <u>Anna Newcatt</u>	MOTHER
RESIDENCE <u>Spencer Idaho</u>		RESIDENCE <u>Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>39</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)
BIRTHPLACE <u>Spencer Idaho</u>		BIRTHPLACE <u>Germany</u>	
OCCUPATION <u>farmer</u>		OCCUPATION <u>housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive Stillborn at 2 P.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) G. M. Walchman

(Physician or midwife)

Address Spencer IdahoFiled Dec 1 1924

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

101. When a child is born, the mother must give a birth report to the health officer. This report must be made within 10 days of the birth. If the mother does not give a birth report, the health officer may take the child to the hospital and the mother may be fined.

PLACE OF BIRTH

CERTIFICATE OF BIRTH

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

STATE OF IDAHO

158610
158610
158610

County of _____
City of _____
Registration District No. _____
State File No. _____

Hospital _____
 Primary Registration District No. _____
 Full Name of Child _____
 (Certificate of no valid without full name of child)
 Sex of Child _____
 Date of Birth _____
 (Month) (Day) (Year)
 Time of Birth _____
 (To be given only in event of special birth)
 Legitimacy _____
 (Legitimate) (Illegitimate)
 What (patronymic) surname was used in event? _____

FATHER		MOTHER	
Full Name	Residence	Full Name	Residence
_____	_____	_____	_____
Color _____	Age at last birthday _____ (Years)	Color _____	Age at last birthday _____ (Years)
Birthplace _____	Occupation _____	Birthplace _____	Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
 (Signature) _____
 (Physician or midwife)
 Address _____
 Filed _____
 Registered _____

Give names of those who were present at birth.
 When there was no attending physician or midwife, then the father, mother, brother, etc., should make this statement. A birth report is one that neither shows nor shows other evidence of life after birth.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of Washington Registration District No. 52
City of Weiser Primary Registration District No. 2112
St. IDAHO

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Glascock

DEPARTMENT OF
BUREAU OF VITALS

CLERK
STICS

State File No. 48301

Local Registrar's No. 46

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

A

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Wht

(Write the word)

6. DATE OF BIRTH

Nov 18 1
(Month) (Day) (Year)

7. AGE

Still Born

IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

Clinton Glascock

11. BIRTHPLACE OF FATHER

(State or Country)

Ida

12. MAIDEN NAME OF MOTHER

Anna Neunert

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Clinton Glascock

15.

Filed

Nov 12

1924

M. R. Haug

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 18 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
19... to 19...
that I last saw him alive on 19...
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

G. M. Waterhouse M. D.

11/11/24

(Address)

Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Hillcrest Cemetery

DATE OF BURIAL

11-11-1924

20. UNDERTAKER

Northam M. E. Cam Weiser &

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

County of WashingtonCity of NeuNo. E. 2nd & R.R.Hospital 818-228044-361

JAN 6 1925

CERTIFICATE OF BIRTH

128625 S

BUREAU OF VITAL
STATISTICSSt. 86 Registration District No.State File No. 188455Primary Registration District No. 1010Local Registrar's No. 107FULL NAME OF CHILD * Hays

(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin Triplet or other? <u>no</u>	and { Number in order of birth } <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Dec 25, 1924</u>
(To be answered only in event of plural births)				(Month) (Day) (Year)

What bactericidal solution was used in eyes? noNumber of child of this mother, including present birth 3Number of child of this mother now living, including present birth 2

FULL NAME FATHER Joseph Henry Hays

RESIDENCE Neu, Ida

FULL MAIDEN NAME MOTHER Lulu Coats

RESIDENCE Neu, Ida

COLOR White AGE AT LAST BIRTHDAY 32

(Years)

COLOR White AGE AT LAST BIRTHDAY 30

(Years)

BIRTHPLACE IdaBIRTHPLACE Mo.OCCUPATION farmerOCCUPATION housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 2 30 a M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) G. M. Hatcher

(Physician or midwife)

Give names added from a supplemental report.

Address Neu, IdaFiled Dec 31 1924

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. R.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

54

254851

7577017-25

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Washington Registration District No. 86
City of Wenatchee Primary Registration District No. 1010
BUREAU OF VITAL STATISTICS

State File No. 48299
Local Registrar's No. 37

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

FULL NAME

Baby Hayse

PERSONAL AND STATISTICAL PARTICULARS

2. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single

(Write the word)

6. DATE OF BIRTH

Dec 28 1924
(Month) (Day) (Year)

7. AGE

Still Born
Yrs. Mos. ds.

IF LESS than 1 day how many
hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Joseph Henry Hayse

11. BIRTHPLACE OF FATHER

(State or Country)

Ill

12. MAIDEN NAME OF MOTHER

Lulu Coates

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Henry Hayse
Wenatchee, Ida

15.

Filed Dec 28 1924 M. H. Knudsen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 28 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec 28 1924, to 1924,

that I last saw him alive on 1924,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Hatcher M. D.(Address) Wenatchee, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Monks Creek Cemetery 12-29-24

20. UNDERTAKER

ADDRESS

Northam M & Co Wenatchee, Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia, (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

PLACE OF BIRTH

STATE OF IDAHO

RECEIVED

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of BlaineCity of BellevueNo. 993123007866 St.

BUREAU OF VITAL

Registration District No. 57

FEB 9 1925

CERTIFICATE OF BIRTH

File No. 128733

Hospital _____

Primary Registration District No. 2022

Registered No. _____

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>yes</u>	Date of birth <u>12</u> <u>23</u> <u>1924</u> (Month) (Day) (Year)
--------------------------	---	-----	---	--------------------------------	--

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FULL NAME <u>Glen Rice</u>	FATHER	FULL MAIDEN NAME <u>Charlotte Grove Howard</u>	MOTHER
RESIDENCE <u>Glendale Idaho</u>		RESIDENCE <u>Glendale Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>31</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)
BIRTHPLACE <u>Rockland Ida</u>		BIRTHPLACE <u>Alexandria Minn</u>	
OCCUPATION <u>Farming</u>		OCCUPATION <u>Wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Shelborn at 10 30 A.M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. H. Reed

(Physician or midwife)

Give names added from a supplemental report.

Address Hailey IdahoFiled 5-1 1925

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

1. PLACE OF DEATH

County of Blaine
 City of Beleeme

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

RECEIVED
FEB 9 1925
BUREAU OF VITAL STATISTICS

Registration District No. 57Registration District No. 2022

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 48599Registered No. 1

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

12 23 1924
 (Month) (Day) (Year)

7. AGE

✓ Yrs. ✓ Mos. ✓ ds.

IF LESS than 1 day
 how many _____ hrs.
 or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Beleeme, Ida

10. NAME OF FATHER

Glen Rice

11. BIRTHPLACE OF FATHER

(State or Country)

Rockland, Ida

12. MAIDEN NAME OF MOTHER

Charlotte G. Howard

13. BIRTHPLACE OF MOTHER

(State or Country)

Alexandria, Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. H. Peedy, M.D.

(Address)

Hailey, Ida

15.

Filed 2-11925W. H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12 23 1924
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

✓ 19 to ✓ 19that I last saw h. _____ alive on _____ ✓ 19

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

E. H. Peedy

M. D.

2/24 1924

(Address)

Hailey, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

912-104 029-279
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

FEB 9 1925

BUREAU OF VITAL CERTIFICATE OF BIRTH
STATISTICS

128909

County of Latah

City of Museu

No. _____ St. _____

Registration District No. 61

File No. _____

Hospital _____

Primary Registration District No. 1011

Registered No. 1

FULL NAME OF CHILD _____

(Certificate of no value without full name of child.)

Sex of
Child

male

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

Feb 4

1924

(To be answered only in event of plural births)

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth... 6

Number of child of this mother now living, including present birth... 4

FULL
NAME

Perry Bass

FATHER

FULL
MAIDEN
NAME

Mary M. Gray

MOTHER

RESIDENCE

Museu

RESIDENCE

Museu

COLOR

white

AGE AT LAST
BIRTHDAY

33

(Years)

COLOR

white

AGE AT LAST
BIRTHDAY

32

(Years)

BIRTHPLACE

Mo

BIRTHPLACE

Wash

OCCUPATION

Laborer

OCCUPATION

House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was...
on the date above stated.

at 11-P
(Residence or stillborn)

M.

* When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

J. N. Clarke

(Physician or midwife)

Give names added from a supplemental report.

Address _____

Filed

Jan 31 1925 M. H. Caruthers
Registrar.

Registrar.

1000

1000

1000

1000

1000

1000

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH. JAN 1923
County of LATAM Registration District No. 2141
City of Moscow (No.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME BARRY BASS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 48141

Registered No. 60

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. CHILD (Write the word.)

6. DATE OF BIRTH

DEC. 4 1924
(Month) (Day) (Year)

7. AGE

Stillborn mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

IDAHO

10. NAME OF FATHER

PERRY BASS

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

MARY SPRAY

13. BIRTHPLACE OF MOTHER

(State or Country)

WASH.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

PERRY BASS

(Address)

Moscow

15.

Filed

DEC. 5 1924

M. H. Baertters

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

DEC. 4 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191., to 191.,

that I last saw h. alive on 191.,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn (8 months)

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. N. Clarke

M. D.

12-4-1924

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs. mos. days.

In the

State

yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

PALOUSE

DEC. 5 1924

20. UNDERTAKER

ADDRESS

H. R. SHORT

Moscow

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

133-227 830-913

County of

Benli

City of

Salman

No.

RECEIVED
FEB 12 1925
BUREAU OF VITAL
STATISTICS

DEPA.

BURE.

CERTIFICATE

S128922

File

Hospital

Primary Registration District No.

4/
2116

Registered No.

FULL NAME OF CHILD

Cenise Pure Allen

(Certificate of no value without full name of child.)

Sex of Child

f.

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

Yes

Date of
birth

12/27

1924
(Month) (Day) (Year)

What bacteriocidal solution was used in eyes?

none

Number of child of this mother, including present birth

7

Number of child of this mother now living, including present birth

4

FULL
NAME

FATHER

Andrew Brown Allen

RESIDENCE

Salman

FULL
MAIDEN
NAME

MOTHER

Lula Paul Rachtman

RESIDENCE

Salman

COLOR

white

AGE AT LAST
BIRTHDAY

34

(Years)

COLOR

white

AGE AT LAST
BIRTHDAY

34

(Years)

BIRTHPLACE

Delaware

BIRTHPLACE

Colorado

OCCUPATION

garage owner

OCCUPATION

housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

still born

7.45 A

M.

(Born alive or stillborn)

{ *When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth. }

(Signature)

Chas. F. Hammer

(Physician or midwife)

Give names added from a supplemental report.

Address

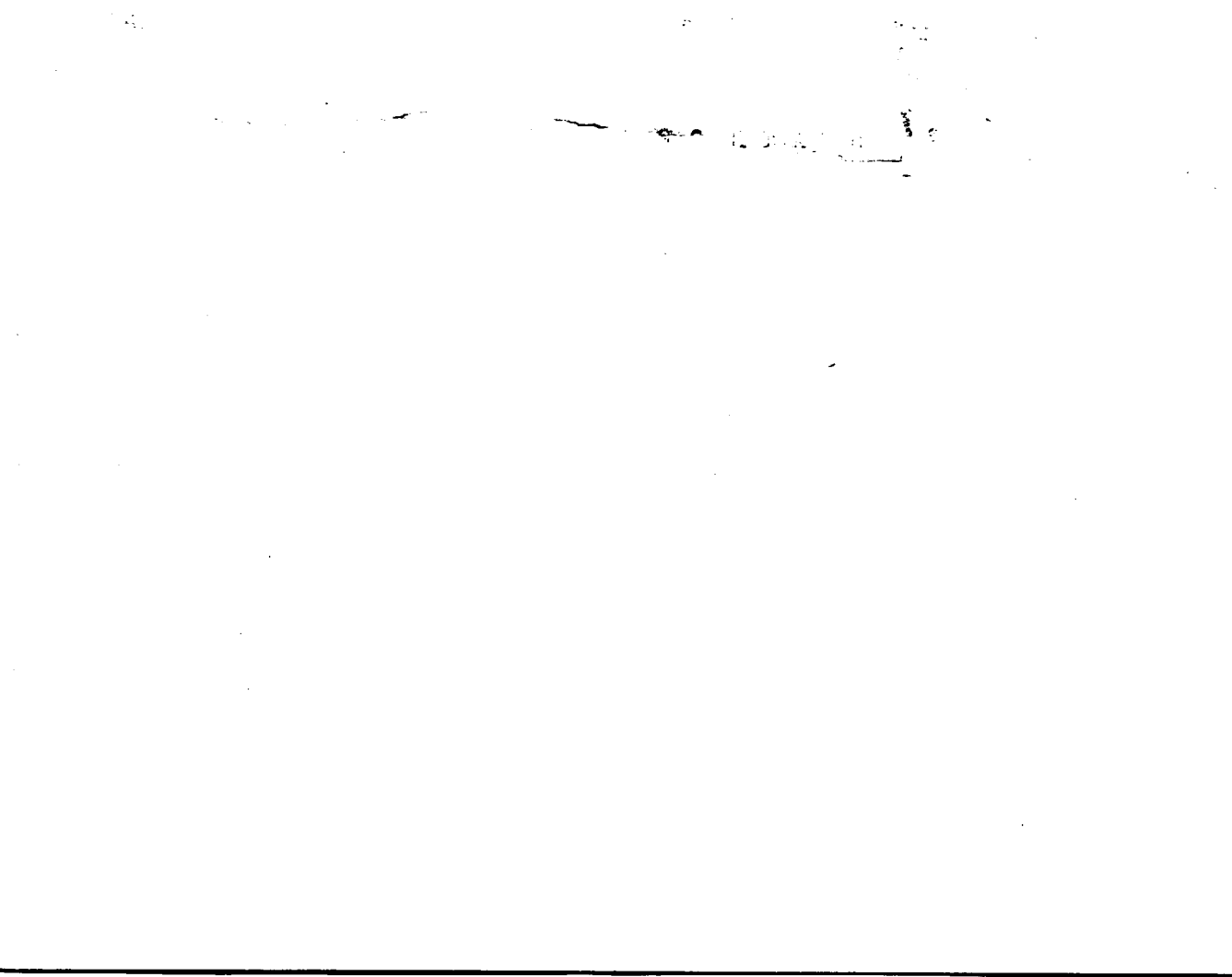
Filed 2-10

1925

M. D. Davis

Registrar.

Registrar.



DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho FEB 13 1925

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet at your earliest convenience in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

* * * *

Place of Birth	{	CITY <u>Salmon</u>	FILE NO. <u>128922</u>
		ST. _____	DATE OF BIRTH <u>Dec 27 1924</u>
		COUNTY <u>Lammi</u>	SEX OF CHILD <u>Female</u>
		FATHER <u>A B Allen</u>	MOTHER <u>Lulu Pearl Rathbun</u> (Maiden Name)

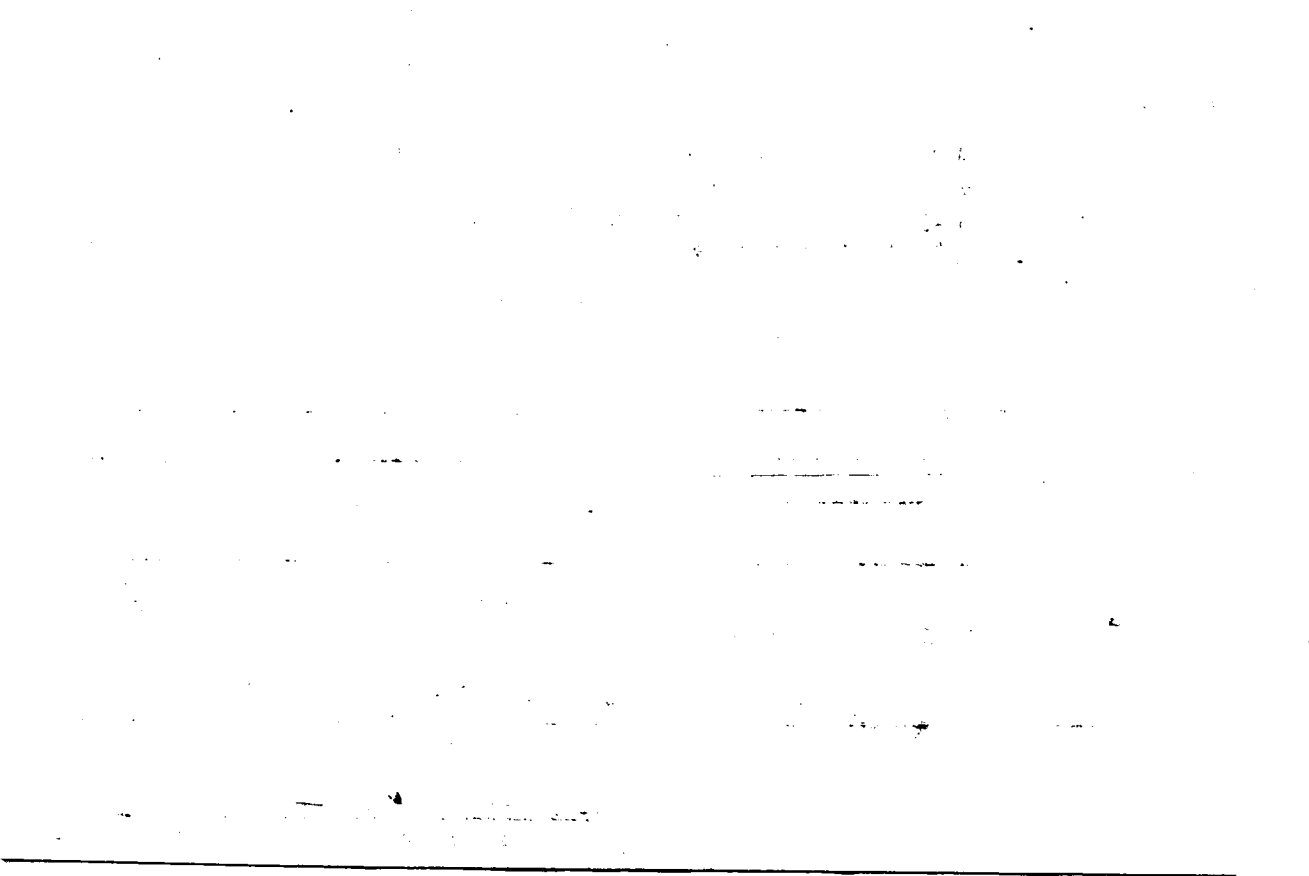
I HEREBY CERTIFY that the child herein described has been named:

RECEIVED

27 1925

OF VITAL
STATISTICSAnise Pearl AllenA B Allen

Signature of Father or Mother.



646 222-035-681
PLACE OF BIRTH

RECEIVED

DEPARTMENT
BUREAUWELFARE
SERVICES

S

FEB 11 1925

CERTIFICATE OF BIRTH

128955

County of Maya PuraCity of Lewisport

No. _____ St. _____

Registration District No. 96

File No.

Hospital whitePrimary Registration District No. 1009

Registered No.

FULL NAME OF CHILD

May Ellen O'Donnell

(Certificate of no value without full name of child.)

Sex of Child 7Twin
Triplet
or other?{ and { Number
in order
of birthLegiti-
mate? yesDate of
birth12/221924

(To be answered only in event of plural births)

(Month)

(Day)

(Year)

What bacteriocidal solution was used in eyes? 10% Argemol

Number of child of this mother, including present birth

Number of children of this mother now living, including present birth

FULL
NAME

FATHER

John Patrick O'Donnell

RESIDENCE

Clarkston, Wn.

COLOR

W.

AGE AT LAST

BIRTHDAY 28
(Years)

BIRTHPLACE

Mo.

OCCUPATION

LaborerFULL
MAIDEN
NAME

MOTHER

Ruth Cecil Wyatt

RESIDENCE

Clarkston, Wn.

COLOR

W.

AGE AT LAST

BIRTHDAY 24
(Years)

BIRTHPLACE

Oklahoma

OCCUPATION

H.W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____ at _____
on the date above stated.

(Born alive or stillborn)

M.

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

H. H. Pounce M.D.

(Physician or midwife)

Give names of _____ from a supplemental report.

Address

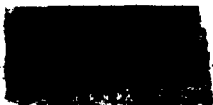
Lewisport, Ida.

Filed

1925Ann E. Bruce

Registrar.

Registrar.



2
STATE

1944

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 48553

1. PLACE OF DEATH

County of PaysonCity of Payson

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 96Primary Registration District No. 1009No. 11

St.)

Registered No. 1898

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
FEB 11 1925
BUREAU OF VITAL
STATISTICS

May Ellen O'Donnell

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

F.W.Single

(Write the word.)

6. DATE OF BIRTH

12 - 22 - 1924
(Month) (Day) (Year)

7. AGE

Yrs.

Mos.

0

ds.

IF LESS than 1 day
how many 0 hrs.
or 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work L

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

John Patrick O'Donnell

11. BIRTHPLACE OF FATHER

(State or Country) Ill.

12. MAIDEN NAME OF MOTHER

Ruth Ethel Wyatt

13. BIRTHPLACE OF MOTHER

(State or Country) Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. F. Paine M.D.(Address) Payson, Idaho

15.

Filed 4/24 5 - 1925Norman E. Paine
Local Registrar

16. DATE OF DEATH

12 - 22 - 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

L 19..... to L 19.....

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Stillbirth(Duration) Yrs. mos. 0 ds.Contributory
(Secondary)(Duration) Yrs. mos. 0 ds.(Signed) H. F. Paine

M. D.

19..... (Address) Payson, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos. 0 days. In the State..... yrs..... mos. 0 daysWhere was disease contracted if not at place of death? LFormer or usual residence L

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Clarkston Wash12/23 1924

20. UNDERTAKER

ADDRESS

RA WhighamClarkston

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED
FEB 27 1924

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Boundary
City of Bonner Ferry
No. 285 223011 344 St. Registration District No. 79 State File No. 129278

BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Hospital Primary Registration District No. 7956 Local Registrar's No.

FULL NAME OF CHILD

Marion Annie Shelley

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? ✓ and { Number in order of birth ✓ Legitimate? yes Date of birth Nov. 33 1924
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

FATHER		MOTHER	
Number of child of this mother, including present birth <u>1</u>	Number of child of this mother now living, including present birth <u>0</u>	FULL MAIDEN NAME <u>Marion A. Shelley</u>	FULL MAIDEN NAME <u>Marquette Cummings</u>
RESIDENCE <u>Bonner Ferry</u>	RESIDENCE <u>Bonner Ferry</u>	COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>25</u> (Years)	COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>20</u> (Years)
BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Idaho</u>	OCCUPATION <u>Laborer</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive { Stillborn } at 9 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) SS Inc

(Physician or midwife)

Address Bonner Ferry, Ida

Filed 11/24/1924

Registrar.

Registrar.

THIS IS A PRELIMINARY REPORT
 AND SHOULD NOT BE USED FOR
 ANY OTHER PURPOSES
 IN THE CASE OF DEATH
 OF A CHILD WHOSE NAME
 IS NOT KNOWN TO THE
 REGISTRAR

Register
 Filed
 Address
 (To be filled in by midwife)
 192

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child who was { } at { } on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc. should make this report. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Give names added from a supplemental report.)

OCCUPATION

BIRTHPLACE

COLOR

AGE AT LAST BIRTHDAY

BIRTHPLACE

OCCUPATION

AGE AT LAST BIRTHDAY

RESIDENCE

RESIDENCE

FULL NAME

FATHER

FULL NAME MAIDEN NAME

MOTHER

Number of child of this mother, including present birth

Number of child of this mother, including present birth

What bactericidal solution was used in case of

Sex of Child

FULL NAME OF CHILD

Hospital

Primary

Birth District No.

CERTIFICATE OF BIRTH

BUREAU OF VITAL STATISTICS
 DEPARTMENT OF PUBLIC HEALTH
 STATE OF IDAHO

2

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

1. PLACE OF DEATH

County of Boundary,

City of Bonnors Ferry,

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marion Annie Shelley,

CERTIFICATE OF DEATH

RECEIVED
FEB 27 1925
BUREAU OF VITAL STATISTICS

Registration District No. 79

Registration District No. 2156 (St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 48703

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED _____

6. DATE OF BIRTH

Nov., 23, 1924.
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day how many hrs. or min.?
Yrs. Mos. Stillborn,

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Bonnors Ferry, Ida.

10. NAME OF

Father Lewis A. Shelley,

11. BIRTHPLACE

OF FATHER
(State or Country) Minnesota,

12. MAIDEN NAME

OF MOTHER Marietta Cummings,

13. BIRTHPLACE

OF MOTHER
(State or Country) Montana.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L.A. Shelley,
(Address) Bonnors Ferry,

15.

Filed Nov. 24 1924 E.E. Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH 1890

16. DATE OF DEATH

Nov., 23, 1924.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19. that I last saw h. alive on 19. and that death occurred on the date stated above, at H.

The CAUSE OF DEATH* was as follows:

Stillborn - Premature
(7 mos.)
(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.
(Signed) E.E. Fry M. D.
11/24/24 (Address) Bonnors Ferry, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.
Where was disease contracted
if not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Bonnors Ferry, Ida.

DATE OF BURIAL

Nov. 24/24

20. UNDERTAKER

ADDRESS

E.E. Fry Bonnors Ferry

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, "PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
612-104004-235
County of Dingle
City of _____
No. _____ St.
Hospital _____
FULL NAME OF CHILD _____

RECEIVED
JUL 3 1925
BUREAU OF VITAL STATISTICS
STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
Registration District No. 5-2
Primary Registration District No. 2136
File No. 132172
Registered No. _____

S

132172

Sex of Child <u>Boy</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of Birth <u>Nov 4 -24</u> (Month) (Day) (Year)
FULL NAME <u>FATHER</u> <u>James Oakey</u>			FULL MAIDEN NAME <u>MOTHER</u> <u>Heola Stewart.</u>		
RESIDENCE <u>Dingle</u>			RESIDENCE <u>Dingle</u>		
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)		COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)	
BIRTHPLACE <u>Wardboro</u>			BIRTHPLACE <u>St Charles</u>		
OCCUPATION <u>Farmer</u>			OCCUPATION <u>Wife</u>		

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Still born (Regulating or stillborn) at I.30 on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report

(Signature) DR G. F. ASHLEY

(Physician or midwife)

Address _____

Filed _____

Registrar

Registrar

UNITED STATES OF AMERICA

DATE

REPORT NO.

PROJECT NO.

REPORT DATE

Page

UNITED STATES OF AMERICA

TO: DIRECTOR
OF THE BUREAU

FROM: [illegible]

(Continued)

337747

250100

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH 119 102 814 638
County of Canyon
City of Nauvoo
No. P#4 St. Registrar's No. 7 State File No. 132382
Hospital _____ Primary Registration District No. 2006 Local Registrar's No. 91
FULL NAME OF CHILD _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

RECEIVED
JUN 25 1926

CERTIFICATE OF BIRTH

(Certificate of no value without full name of child)
Sex of Child male Twin Triplet ☒ and { Number in order of birth 4 } Legiti- mated? yes Date of birth 5/2 1924 (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3
FULL NAME FATHER J. Jarowski FULL NAME MOTHER Stella Ochmanski
RESIDENCE P#5 Nauvoo RESIDENCE P#5 Nauvoo
COLOR White AGE AT LAST BIRTHDAY (Years) COLOR White AGE AT LAST BIRTHDAY (Years)
BIRTHPLACE Poland BIRTHPLACE Poland
OCCUPATION Farmer OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was ~~born alive~~ Stillborn { at 11:06 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make the return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) Geo W Chittor MD

(Physician or midwife)

Address

Filed

Registralr.

Registralr.

STATE OF MISSISSIPPI
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

County of Jefferson
No. 135388
Hospital St. Vincent

FULL NAME OF CHILD John William
Sex Male
Date of Birth April 10, 1941
Time of Birth 11:00 AM
Place of Birth St. Vincent Hospital
Weight 10 lbs.
Length 19 in.
Head 13 in.
Chest 13 in.
Arm 10 in.
Leg 10 in.
Foot 5 in.
Finger 1 in.
Palm 1 in.
Heel 1 in.
Ankle 1 in.
Instep 1 in.
Nose 1 in.
Mouth 1 in.
Ears 1 in.
Eyes 1 in.
Hair 1 in.
Skin 1 in.
Birthmarks 1 in.
Scars 1 in.
Tattoos 1 in.
Other 1 in.

What vaccination or injections were used in case?
Name of physician attending birth Dr. J. W. Smith
Name of midwife attending birth Miss M. J. Smith
Name of nurse attending birth Miss M. J. Smith
Name of doctor attending birth Dr. J. W. Smith
Name of hospital attending birth St. Vincent Hospital
Name of city attending birth St. Vincent
Name of state attending birth Mississippi
Name of country attending birth United States

RESIDENCE St. Vincent
COLOR White
BIRTHPLACE St. Vincent
OCCUPATION None
EDUCATION None
RELIGION None
MARRIAGE None
MOTHER None
FATHER None

PHYSICIAN OR MIDWIFE Dr. J. W. Smith
Nurse Miss M. J. Smith
Midwife Miss M. J. Smith
Doctor Dr. J. W. Smith
Hospital St. Vincent
City St. Vincent
State Mississippi
Country United States

I hereby certify that I attended the birth of the child above named on the date above stated.
When there was no attending physician or midwife, then the father, husband or mother should make the statement. A statement should be made by the father or mother if one of them was present at the birth of the child.
Give names added from supplemental statement.

Signature of physician Dr. J. W. Smith
Signature of midwife Miss M. J. Smith
Signature of nurse Miss M. J. Smith
Signature of doctor Dr. J. W. Smith
Signature of hospital St. Vincent
Signature of city St. Vincent
Signature of state Mississippi
Signature of country United States

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

S

DEPARTMENT OF PUBLIC WELFARE

NOV 2 1925

BUREAU OF VITAL STATISTICS

County of BoundaryCity of Bonner FerryBUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

135379

No. 582-211011-231St. Registration District No. 29

State File No.

Hospital Bonner FerryPrimary Registration District No. 1st

Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child FemaleTwin
Triplet
or other?

and {

Number
in order
of birth

{

Legiti-
mate?yes.Date of
birthNov. 11 1924What bactericidal solution was used in eyes? 1

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth 1FULL
NAME

FATHER

Oscar Bernard Nystrom

RESIDENCE

Moravia, Ida.

COLOR

whiteAGE AT LAST
BIRTHDAY34
(Years)

BIRTHPLACE

Sweden

OCCUPATION

LaborerFULL
MAIDEN
NAME

MOTHER

Alma Bearwald

RESIDENCE

Moravia, Ida.

COLOR

whiteAGE AT LAST
BIRTHDAY34
(Years)

BIRTHPLACE

H. Dakota

OCCUPATION

Housewife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { born alive } at 8 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Bonner Ferry, Ida.

Filed

11/17/1924

192

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

2002

659-230-240-791
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-2-3-17

OCT 21 1914

CERTIFICATE OF BIRTH

S

County of Shoshone

City of Wallace

No. Wallace Hosp. St.

Hospital Wallace Hosp.

Registration District No. 70

Primary Registration District No. 101

File 135770

Registered No. 34

FULL NAME OF CHILD Stillborn

Sex of Child <u>female</u>	Twin Triplet or other? <u>1</u> } and { Number in order of birth <u>1st</u> } (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of Birth <u>Dec 30</u> 19 <u>14</u> (Month) (Day) (Year)
FATHER FULL NAME <u>Alexander Terrot</u> RESIDENCE <u>Wallace</u> COLOR <u>Italian</u> AGE AT LAST BIRTHDAY <u>27</u> (Years) BIRTHPLACE <u>Italy</u> OCCUPATION <u>yardman in mine</u>		MOTHER FULL MAIDEN NAME <u>Lena Grachino</u> RESIDENCE <u>Wallace</u> COLOR <u>Italian</u> AGE AT LAST BIRTHDAY <u>23</u> (Years) BIRTHPLACE <u>Wyoming</u> OCCUPATION <u>H.W.</u>	

Number of child of this mother, including present birth..... Number of children of this mother now living, including present birth.....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

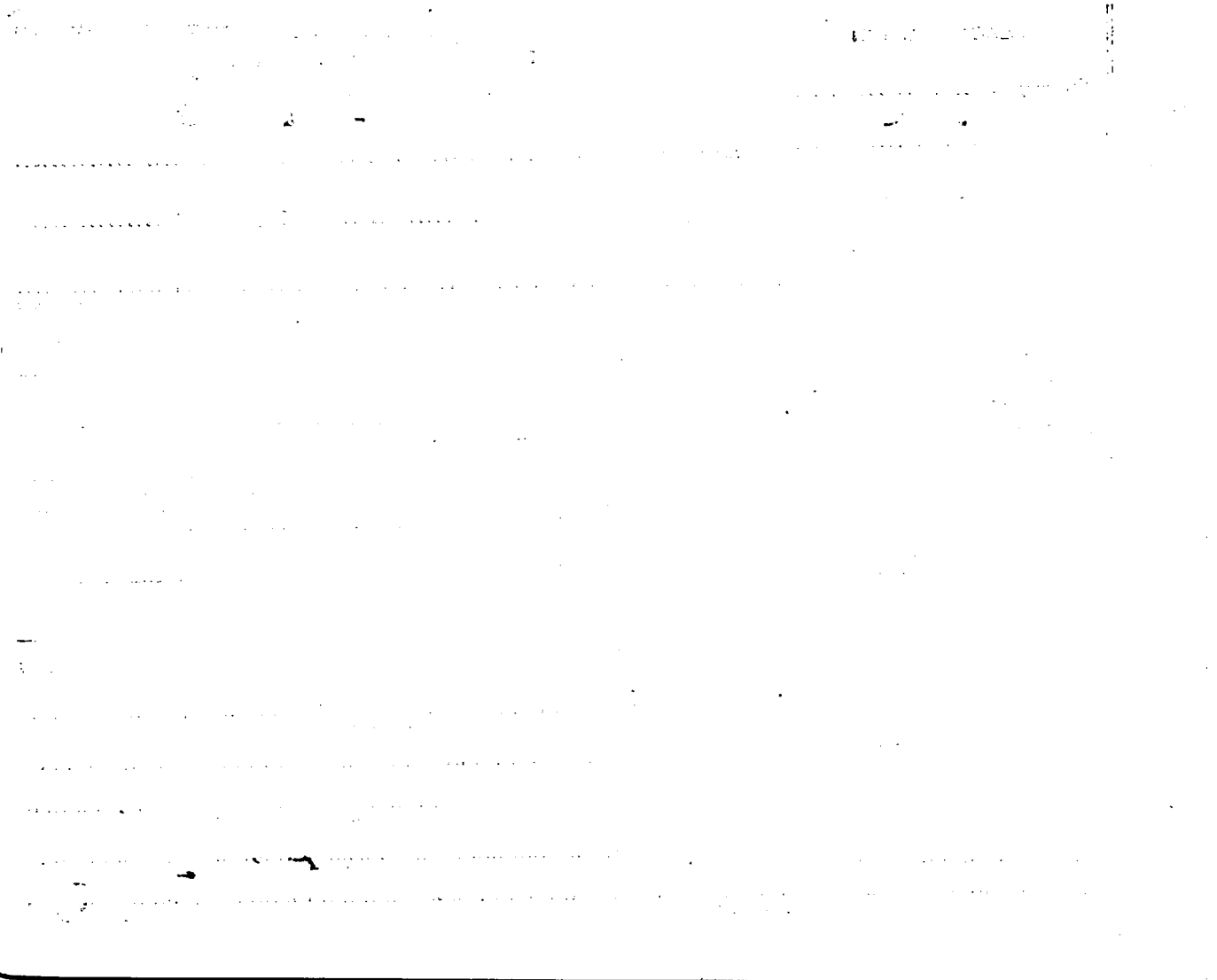
I hereby certify that I attended the birth of this child, who was..... at 12:50 P. M. on the date above stated.

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) James K. Jean (Physician or midwife)
Given names added from a supplemental report.....
.....19.....
.....19.....

Registrar

Address.....
Filed Aug 19 1915 F. L. Jambury
Registrar



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

County of *Shoshone*

City of *Mullan*

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

RECEIVED
JAN 18 1925
BUREAU OF VITAL STATISTICS

Registration District No. *70*

Registration District No. *1011*

Local Registrar's No. *1011*

2. FULL NAME *Maester Ferrett*

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. *48244*

Local Registrar's No. *1011*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male

White

(Write the word)

6. DATE OF BIRTH

Dec

30

1924

(Month) (Day) (Year)

7. AGE

Stieborn

IF LESS than 1 day how many

hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Alex Ferrett

11. BIRTHPLACE OF FATHER

(State or Country)

Italy

12. MAIDEN NAME OF MOTHER

Lena Giachino

13. BIRTHPLACE OF MOTHER

(State or Country)

Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alex Ferrett

(Address)

Mullan 244

15.

Filled

Dec 31

1924

7 8 24

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December

30

1924

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw h. alive on

19

and that death occurred on the date stated above, at *12:15* M.

The CAUSE OF DEATH* was as follows:

Stieborn

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

James R. Bean

M. D.

12/30/24

(Address)

none

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death

yrs. mos. days.

State

yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or

usual residence

none

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mullan 244

Dec 31 1924

20. UNDERTAKER

ADDRESS

Ward Vud Co

Mullan 244

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia") Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

693-206.001-465
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Ada

City of Battle

No. 1 St. Registration District No. 2 State File No. 14834

Hospital St. Lukes Primary Registration District No. 1004 Local Registrar's No. filed

FULL NAME OF CHILD Edith Wilson

(Certificate of no value without full name of child)

Sex of Child T

Twin
Triplet
or other?

} and { Number
in order
of birth
(To be answered only in event of plural births)

Legiti-
mate? yes

Date of
birth 10 6 1924

(Month) (Day) (Year)

What bactericidal solution was used in eyes? Nothing

Number of child of this mother, including present birth 1

Number of child of this mother now living, including present birth 1

FULL
NAME

FATHER

Geo C Wilson

RESIDENCE

Battle

COLOR

W

AGE AT LAST
BIRTHDAY 36
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Ethel E Montath

RESIDENCE

Battle

COLOR

W

AGE AT LAST
BIRTHDAY 34
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive Stillborn at 11:30 A M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

William J. Japlin
Physician
(Physician or midwife)

Address

Battle Idaho

Filed 1-12

192 7

R. H. Pratt

Registrar.

Registrar.

Dep of 1924-149213

PLACE OF DEATH

County of *Ada*City of *Boise*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

CERTIFICATE OF DEATH

Registration District No. *2*
Primary Registration District No. *1007*
312 E. Bannock St.State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *47180*Registered No. *256*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Edith Wilson*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)6. DATE OF BIRTH *Oct 6 1924*
(Month) (Day) (Year)7. AGE *—* Yrs. *—* Mos. *—* ds.IF LESS than 1 day
how many *—* hrs.
or *—* min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *none*
(b) General nature of industry, business or establishment in which employed (or employer)9. BIRTHPLACE *Boise, Idaho.*
(State or Country)10. NAME OF FATHER *George E. Wilson*11. BIRTHPLACE OF FATHER *Idaho*
(State or Country)12. MAIDEN NAME OF MOTHER *Ethel E. Monticelli*13. BIRTHPLACE OF MOTHER *Neb.*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Geo. C. Wilson*

(Address)

15.

Filed *Oct. 7 1924*Local Registrar *R. H. Pratt*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Oct 6 1924*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Oct 6 1924* to *Oct 6 1924*that I last saw *her* alive on *Oct 6 1924*and that death occurred on the date stated above, at *12* M.The CAUSE OF DEATH* was as follows:
Starvation

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *M. C. Canning-Jafflin* M. D.1924 (Address) *511 E. Bannock Boise Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence *Boise, Ida*19. PLACE OF BURIAL OR REMOVAL *Harris Hill*DATE OF BURIAL *Oct 7 1924*20. UNDERTAKER *Schreiber & Sidungaden*ADDRESS *Boise*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

792126003 366

PLACE OF BIRTH JUL 5 1927

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

County of Bannock

City of Grace

Registration District No. 84

File No. **S 152613**

No. _____ St. _____

Primary Registration District No. 2161

Registered No. 360

Hospital _____

FULL NAME OF CHILD No name

Sex of Child <u>Male</u>	Twin Triplet or other? _____ and _____	Number in order of birth _____	Legitimate? <u>Yes</u>	Date of Birth <u>Feb 26</u> 192 <u>7</u> (Month) (Day) (Year)
--------------------------	--	--------------------------------	------------------------	--

FATHER
FULL NAME Harvey Libson

RESIDENCE Grace - Idaho

COLOR White AGE AT LAST BIRTHDAY 46
(Years)

BIRTHPLACE Franklin - Idaho

OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Lucy Lowe

RESIDENCE Grace - Idaho

COLOR White AGE AT LAST BIRTHDAY 39
(Years)

BIRTHPLACE Franklin Idaho

OCCUPATION Housewife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 5: P. M. on the date above stated. (born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) John Hubbard
Physician
(Physician or midwife)

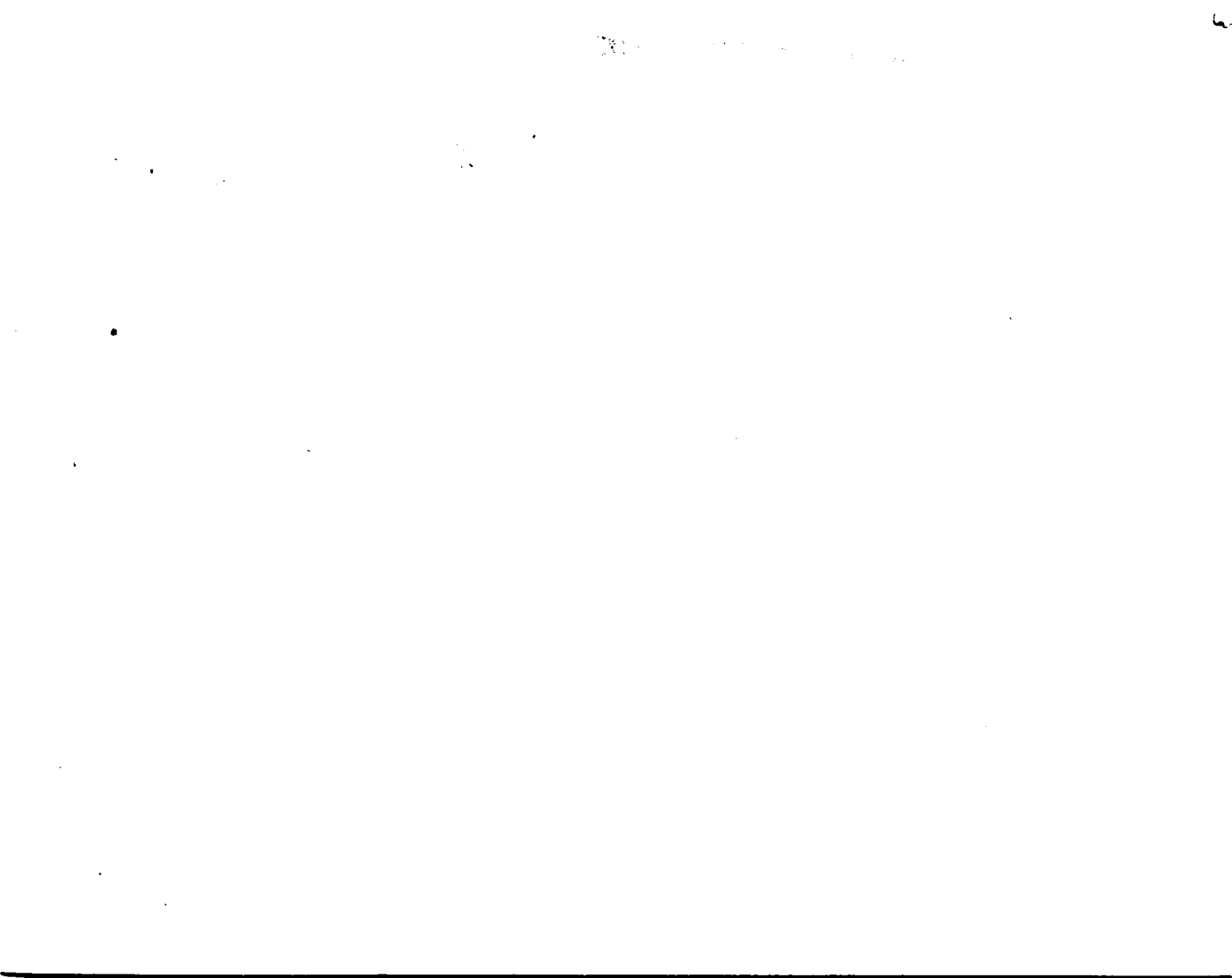
Given names added from a supplemental report.

Address Grace - Idaho

Filed 6/25 1927 Mrs. J. J. Feb

Registrar

Registrar



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

845-226-0315-315

PLACE OF BIRTH

RECEIVED JAN 9 1928

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Lewis

City of Russell Idaho

CERTIFICATE OF BIRTH **158018**

No. Ross St. Registration District No. 47 State File No. _____

Hospital _____ Primary Registration District No. _____ Local Registrar's No. 318

FULL NAME OF CHILD

Khoda Walter Hunter

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? None and { Number in order of birth 1 Legitimate? Yes Date of birth Apr 26 1924
(To be answered only in event of plural births) (Monthly) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 4

FATHER
FULL NAME

Milton N. Hunter

RESIDENCE

Russell, Ida

COLOR

White

AGE AT LAST BIRTHDAY 33
(Years)

BIRTHPLACE

Mo.

OCCUPATION

Farmer

MOTHER
FULL MAIDEN NAME

Frances G. Langdon

RESIDENCE

Russell, Idaho

COLOR

White

AGE AT LAST BIRTHDAY 37
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } { Stillborn } 15 M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Milton N. Hunter

Father

(Physician or midwife)

Dr. R. E. D.

Address

Filed 12-31-1927

Alburt Huff

Registrar.

Registrar.

